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Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, October 2, 1884.

The President, R. A. Cleeman, M.D., in the Chair.

Dr. B. F. Baer exhibited specimens from a case of

SUBMUCOUS AND INTERSTITIAL FIBRO-CYSTIC TUMOR OF THE UTERUS, IN WHICH HEMORRHAGE WAS ABSENT.

Mrs. H., æt. 36 years, has had two children, the youngest being twelve years of age. Four years ago she suffered from severe metrorrhagia, which was caused by a submucous and interstitial fibroma of the uterus. This was removed and, after passing through a severe attack of peri-uterine inflammation, she recovered. After the removal of the growth her catamenial periods became regular in time and quantity and she remained well until about one year ago, when she began to have a very fetid watery discharge in the intermenstrual periods with sacral pain and uterine tenesmus.

On July 17th, her physician, Dr. R. Armstrong, of Lock Haven, requested me to see her with him, when examination showed the cervix to be twice its normal size with swollen and gaping lips making the os and cervical canal quite patulous. The body of the uterus was as large as at the third month of gestation, but it was not symmetrically developed, being larger on the left than on the right side. The left broad ligament was indurated and seemed to be the seat of an old inflammatory process. Pain had been present in this region since the operation. The sound met with an obstruction at the internal os and was deflected to the right, passing to a depth of nearly four inches. It could be made to pass around a mass of some kind in the cavity of the uterus, giving an indistinct sensation of the presence of an abnormal growth. I expressed the opinion that although there had been no hemorrhage there was a submucous or polypoid fibroma present, and advised its removal. Seven tents were introduced and twenty-four hours later ether was administered, when, with the assistance of Drs. Armstrong, Walls and Ball, I proceeded to remove the tents and explore the uterine cavity. On passing my finger within the internal os, I detected a smooth oval-shaped mass of tissue resembling in consistency the inverted uterus enlarged to about double its normal size. I carried my finger up with some difficulty and

found the base or attachment of the tumor to be located at the fundus of the uterus where it was narrowed somewhat forming a sort of pedicle. The tumor felt rather soft for a fibroma, and this, together with its shape, caused me to suspect inversion of the uterus, and when I remembered that the organ is sometimes inverted by the operation for the removal of an interstitial fibroid which requires great traction, as was necessary in this case four years previously, I became much more anxious to investigate fully before attempting to remove the mass. By very careful and thorough bi-manual manipulation I convinced myself that the uterus was not inverted, there was no indentation anywhere on its surface. I therefore felt warranted in adjusting the wire of an écraseur around its attachment and proceeded to tighten it, but the traction and manipulation which were necessary in placing the noose broke the surface of the tumor and exposed a peculiar looking membrane which resembled the peritoneum. I was alarmed at this, fearing that I had really to deal with a partially inverted womb and that the smooth membranous surface was the peritoneum. I removed the écraseur, the wire of which had broken, and then passed one finger into the bladder and another into the rectum for the purpose of determining more certainly the condition of the peritoneal surface of the uterus. Now, while an assistant made traction on the supposed tumor, I was enabled to satisfy myself fully that the organ was not inverted. I then removed the tumor by enucleation.

As you will see in the specimen which I present there are a number of cysts. These cysts contained the semi-opaque coagulable fluid usually found in fibro-cysts and gave to the tumor its softness which, together with its shape and the appearance of the cyst-walls when its surface was broken, made it resemble an inverted uterus. The patient made a good recovery.

The case is very unusual for the reason that, although the uterine cavity was distended by a large submucous tumor which was becoming polypoid, not the slightest hemorrhage resulted. I do not remember to have met with a similar case. I have, however, met with cases of small polypi where there was no hemorrhage, two indeed were discovered after the menopause had been fully established and are worthy of record because of the reflex symptoms which they seemed to induce.

Uterine Polypus in which Hemorrhage was Absent but which Gave Rise to Symptoms of Pregnancy.

Mrs. C. was forty-six years of age, she had been married twenty years but had never been pregnant. The menopause had occurred one year previous to the date at which I saw her. Soon after the cessation of the catamenia her abdomen began to enlarge and she thought she was pregnant. Various irregular reflex symptoms of pregnancy developed and she became so convinced that she engaged the services of an accoucheur and nurse and went into labor in due time. Her physician, my friend

Dr. John H. Musser, was unable to discover the least physical sign of gestation, nor anything else which should give rise to the almost perfect labor-like pains which she seemed to have at irregular intervals. He informed her that she was not pregnant. She became indignant and asked him to call another physician to confirm what he said. He consented and requested me to see the patient. I excluded pregnancy, but found in the cervical canal a fibrous polypus not larger than an ordinary marble. This I at once removed and the pains and other signs of gestation immediately subsided.

This was one of those cases of spurious pregnancy which we sometimes see developed in a sterile woman about the period of the menopause. The desire for offspring is strong. The cessation of the menses starts the delusion and it is kept in existence and made to grow by being constantly fed by a morbidly susceptible nervous system. But there was a local irritation here to account for the reflex symptoms of gestation, as I believe there is in the majority of these rare and interesting cases. It is three years since this patient was under treatment and there has been no return of the reflex disturbance.

The other case to which I wished to refer occurred in the practice of my friend, Dr. B. Trautman, who kindly asked me to see the patient with him:

UTERINE POLYPUS IN WHICH HEMORRHAGE WAS ABSENT BUT WHICH SEEMED TO INDUCE SEVERE REFLEX HEAD SYMPTOMS.

Mrs. K., æt. fifty-two years, has had two children, the youngest being twenty-five years of age. The menopause had occurred four years previously and she did not complain of the slightest local symptom of uterine disease; but the flushings and other nervous manifestations which often attend this period had not yet subsided. The disturbances, however, which concerned her most, and for which she consulted the doctor, were a pain and pressure of a very aggravated form on the top of the head. Many remedies had been prescribed for the relief of this, but with only temporary benefit. A uterine examination was made and a polypus resmbling in size a small walnut discovered in the canal of the cervix. This was removed some months ago, and I believe the patient has been relieved of the headache and other reflex symptoms which seemed to result from its presence.

The influence which these small growths have on the nervous system is something remarkable. But the absence of hemorrhage, especially in the first case, is more notable when we recall its size and location, and remember that death has resulted from the hemorrhage caused by polypi not larger than a pea, as recorded by Lock, Kleb, Courty and others. I have no doubt some of you can recall cases, as I can, where death would doubtless have resulted from the hemorrhage produced by a small

polypus, had not the cause of it been removed. The following is an illustrative case:

Uterine Polypus attended with Great Hemorrhage.

Mrs. P. consulted me on September 20, 1883. She was thirty years of age and had been married eight years but has been sterile. Two years ago she began to suffer from menorrhagia with uterine tenesmus. Soon after she lost blood at irregular intervals and in large quantities; during the past year she had not often been free from metrorrhagia or a profuse and offensive leucorrhea. The hemorrhage would sometimes last a whole month continuously and leave her so prostrated and anemic that it was thought she could not rally. She had lost thirty pounds in weight and was blanched in appearance.

I will confess that I was surprised to find on examination that my patient had a polypus not larger than a Concord grape; but the mucous membrane of the cavity of the uterus was hypertrophied and granular. The pedicle was attached far up in the cavity of the uterus. The tumor was removed by means of the curette. The patient now menstruated regularly. This case contrasted strongly with the three others in its hemorrhagic character, and it presents the history commonly met with in these growths. There is no doubt that the location of the tumor has great influence in the causation of hemorrhage in these cases, much greater than the size of the growth; but much also depends upon its histological character and the condition of the endometrium. Thus, when a fibroid tumor or polypus is situated in the cavity of the uterus proper, more hemorrhage is likely to result than when it grows from the tissues of the cervix, because if located in the former position it is often of the muscular variety and therefore more vascular, and the mucous membrane of the uterine cavity which is the direct source of the hemorrhage, is usually hypertrophied and granular as in the last case narrated. Moreover, when the cavity of the uterus is the seat of a polypus, the uterine and pelvic circulation is stimulated by its presence, somewhat in the manner in which it is affected by the presence of a fecudated ovum which has been blighted; it is a foreign body and the uterus tries to expel it, but by the effort the circulation is excited in that direction and hemorrhage results. My first case, however, furnishes an exception to the rule that hemorrhage attends when the tumor occupies the uterine cavity, but as tenesmus was present it is possible that hemorrhage might have occurred later had the tumor been allowed to remain.

Dr. Goodell remarked that the question of hemorrhage in polypi is a curious one. It seems less likely when the tumor is in the body of the uterus, and checks the amount of circulation by existing tonic contractions than when it is protruding into the vagina like the clapper of a bell. In one case, where the hemorrhage had produced extreme anemia, dialyzed iron was given to relieve the anemia and it also checked the hemor-

rhage. In another case operation was refused and death resulted from hemorrhage three days after the visit.

Dr. Wm. Goodell reported the following:

RAPID DILATATION OF THE UTERINE CANAL.

For many years I enlarged or straightened the uterine canal, according to the requirements of the case, either by tents or by Sims' operation, and preferably by the former. Having had several serious warnings in the shape of inflammation following these operations, I began to perform them with fear and trembling. Yet nothing very untoward happened until the year 1878, when two grevious mishaps befell me.

A charming young lady, the centre of a large circle of admiring friends, came from a neighboring State to consult me about a dysmenorrhea which grew worse and worse every year. The cervix was so bent forward, and the stenosis of its canal *per se*, as well as by angulation was so marked, that I unhesitatingly performed Sims' operation. Within a few days septicemia set in, soon the parotid glands swelled up and on the ninth day she died. True it is, that, at the same time, two piles also were tied, but this latter operation I had, and have, performed so many times with impunity that I was, and am still, disposed to attribute the blood-poisoning to traumatism of the cervix and not to that of the rectum. Hardly had I time to recover from this bitter blow when a case of exhausting menorrhagia fell into my hands. The lady was the young bride of a husband well advanced in life, who doted on her as only old men dote on much younger wives. I dilated the cervical canal with tents and curetted many vegetations from the endometrium. A furious peritonitis set in and in less than three days this young wife lay dead and the husband was frantic with grief.

The anguish which I felt at the death of these two ladies and the heart-rending scenes which I witnessed at their bedside—scenes which I cannot now recall without emotion—urged me to try any remedy that gave promise of efficiency combined with greater safety. In the search for a substitute, I tried rapid dilatation, which Ellinger and others had proposed, and since that year—that *annus iræ*—I have not once performed Sims' operation for dysmenorrhea, and I have so narrowed the field for the use of tents that I now very rarely resort to them. In short, rapid dilatation has proved, in my hands, so safe and so efficient an operation that I wise to urge its claims before this Society.

The instruments which I would recommend are two Ellinger dilators of different sizes. These are the best on account of the parallel action of their blades. The smaller of these dilators has slender blades and it pilots the way for the other, which is more powerful and with blades that do not feather. I have had the beaks of these dilators changed from an obtuse angle to a slight curve so that it can be reversed within the womb. The light instrument needs only a ratchet in the handles, but the stronger

one should have a screw with which to bring the handles together. Lest the beak should hit the fundus uteri and seriously injure it when the instrument is opened, the blades are made no longer than two inches, and are armed with a shoulder which prevents further penetration. The larger instrument opens to an outside width of one and a half inches and it has a graduated arc in the handles by which the divergence of the blades can be read off. The instruments which I now exhibit to you and which I can recommend highly have been made under my supervision by Messrs. J. H. Gemrig & Son, of this city.

In a case of dysmenorrhea or of sterility, from flexion or from stenosis, my mode of performing the operation of rapid dilatation is as follows: The patient is thoroughly anæsthetized and a suppository containing one grain of the aqueous extract of opium is slipped into the rectum. She is then placed on her back and drawn to the edge of the bed, the knees being supported by her nurse. The light must be good so that the operator may clearly see what he is about. By the aid of a strong tenaculum, applied through my bivalve speculum, the cervix is steadied and the smaller dilator is introduced as far as it will go. Upon gently stretching open that portion of the canal which it occupies, the stricture above so yields that when the instrument is closed it can be made to pass up higher. Thus, by repetitions of this manœuvre, little by little, in a few minutes time a cervical canal is tunneled out, which before could not admit the finest probe. Should the os externum be a mere pin-hole or be too small to admit the beak of the dilator it is enlarged by the closed blades of a straight pair of scissors which are introduced with a boring motion. As soon as the cavity of the womb is gained the handles are brought together. The small dilator being now withdrawn the larger one is introduced and the handles are then slowly screwed together. If the flexion be very marked, this instrument, after being withdrawn, should be re-introduced with its curve reversed to that of the flexion and the final dilatation then made. But, in doing this, the operator must take good care not to rotate the womb on its axis and not to mistake the twist for a reversal of flexion. The ether is now withheld, and the dilator kept in situ until the patient begins to flinch when the instrument is closed and removed. A few drops of blood trickle out of the os. Occasionally a slight flow of blood will last for several days after the operation, simulating the menstrual flux. Often this flux is precipitated or renewed if the operation follows or precedes it too soon. The best time for dilatation is therefore midway between two monthly periods.

When compared with the cutting operation this one looks like rough usage, yet the woman rarely needs more than two or three suppositories, and complains merely of soreness for one or two days. To forestall any tendency to metritis she is kept in bed until all tenderness has disappeared. Pain is met by rectal suppositories of opium and by large

poultices laid over the abdomen. I have seen slight pelvic disturbance arise from this operation, but it has always been readily controlled and has not given alarm.

In the great majority of cases I dilate the canal, not to the full capacity of the instrument, but to one and a quarter inches. Sometimes in an infantile cervix which does not readily yield and might give way, the handles are not screwed down more than three-quarters of an inch or an inch. Tearing of the cervix has happened in two of my cases. In one, that of a virgin, the cervix was split half-way down to the vaginal junction. The other case was that of a multipara, whose uterine canal had been nearly closed up by applications of silver nitrate, made by her physician with the view of curing what he supposed was an "ulceration of the os," but which was a bilateral laceration. The tissues rendered cicatricial and brittle by the caustic were torn by the dilator for about half an inch on the right side also. Here the hemorrhage was free enough to need styptic applications and a tampon. I could have stopped it by wire sutures, but this was not done as it would have defeated the object of the operation.

For slight dilatations, such as for the office treatment of anteflexions and of stenosis or for the introduction of the curette, or of the applicator armed with cotton, the more delicate instrument is quite strong enough, and an anæsthetic is not needed. Sometimes, in a very sharply anteflexed womb, the dilator cannot be made to pass the os internum. This difficulty is overcome by first passing in a surgeon's probe, and then, along it as a guide, the dilator.

After a forcible dilatation under ether, the cervical canal rarely returns to its previously angular or contracted condition. Since lateral extension of elastic bodies antagonizes their length, the cervix shortens and widens; and the plasma provisionally thrown out by the submucous lesions sustained by the dilated part serves still further to thicken and stiffen its tissues. In other words, the stem-like neck of the pear-shaped womb is shortened, widened, strengthened and straightened. Hence, for straightening out anteflexed or congenitally reflexed wombs, and for dilating and shortening the canal in cases of sterility or dysmenorrhea, arising from stenosis or from a conical cervix, the dilator will be found a most efficient instrument. In its results it is not infallible; I have twice been obliged to repeat the operation, and would like to have done so in several other cases, had the women permitted it. In a very few instances I have been forced, as a final resort, to nick a pin-hole os externum; but I had not then learned how far I could safely stretch open the uterine canal, and the operation of dilatation was not so efficiently performed by me as it is now through a larger and riper experience.

But it is not only to cases of dysmenorrhœa that I limit the operation of rapid dilatation. As before stated, I use it to stretch open the canal

for admission of the curette, and of sponge tents, and for the purpose of making applications to the uterine cavity. In cases needing irrigation of the uterine cavity I first dilate the canal with this instrument and introduce the nozzle of the syringe between its distended blades. This gives a free avenue for the escape of the liquid, and robs of its dangers this form of intrauterine medication. I also resort to the dilator in order to explore the womb with the finger. For instance, in any given case of menorrhagia in which a polypus or some other uterine growth is suspected, instead of using sponge tents, I put the woman under anæsthetic, and after the rapid dilation of the cervical canal to the utmost extent of the instrument, viz., one and one-half inches, am enabled to pass my finger up to the fundus. This is accomplished either by drawing down and steadying the womb by a volsella forceps, or in thin subjects by forcing the womb down upon the finger by supra pubic pressure on its fundus. In this way I have over and over again at one sitting discovered an uterine growth, twisted it off and removed it. Usually in these cases I experienced more difficulty in removiug the polypus or other growth through the narrow canal than in twisting it off from its uterine attachment. It often has to be wire drawn before it can be removed, and sometimes the os uteri has a few nicks. Usually when the metrorrhagia is free the cervical tissues are so loose that there is no difficulty in the introduction of the index finger up to the fundus, but sometimes only its tip can be made to pass the os internum. Yet even this limited degree of penetration is commonly quite sufficient to decide the presence of an inside growth. If it is not enough I invariably search for a growth with a small pair of fenestrated forceps, and I have frequently seized and removed one, the existence of which had been merely suspected. After such operations the uterine cavity is thoroughly washed with a solution of carbolic acid, or of potassium permanganate.

I am sorry to say that I have not kept full records of all my cases of rapid dilatation. For instance I have never recorded those office cases of rapid dilatation in which ether was not administered. Nor has any note been made in which dilatation was performed under ether for curetting, for digital exploration of the endometrium, or for the removal of uterine growths. I have tabulated merely cases of dysmenorrhœa in single or married women. In the married women, with but three exceptions, which will be noted, painful menstruation was accompanied by sterility.

Including all the cases of dilatation performed under ether, I must have had over three hundred. I have limited myself to these cases because the use of an anæsthetic implies full dilatation — one in which serious injury, if ever, would most likely be sustained. Yet there has not been a death, nor even a case of severe inflammation in my practice, and the results have been most satisfactory, far more so than when the cutting operation was performed by me.

The following are the statistics of my cases of dysmenorrhœa:

Unmarried,	80
Married,	88
Total,	168

Of the unmarried 18 were unheard from after the operation, leaving 62 from which data could be obtained. Of these, 38 were cured, 17 more or less improved, and 7 not improved at all. Of these 7 that were not benefitted by the operation, 5 subsequently had their ovaries removed, one by another physician and four by myself; of the latter, one died. In each one the ovaries had been so altered by cystic or by interstitial degeneration as to make the dysmenorrhœa otherwise incurable. Of the 17 improved, there was one on whom oöphorectomy was also performed, for although the dysmenorrhæa was greatly relieved by the dilatation, ovarian insanity and menorrhagia were not. The operation was a successful one, and my patient was not only cured of her hemorrhages, but also regained her reason.

Out of these cases, the majority, though not wholly cured, were greatly improved. For instance, one of them was formerly bedridden through the whole period of her menstrual flux, and had then to take large doses of morphia. She also suffered at those times from hematemesis and epistaxis. Since the operation she experiences pain for merely two hours, needs no anodyne, and has lost her ectopic hemorrhages. Her gain in health and flesh has been great. Another one, which was wholly crippled by her sufferings, and made nervous by her dread of them, is now a busy nurse. For one hour at every period she suffers a great deal, but she is too much afraid of taking ether to have a second dilatation performed.

Of those cured, two had had Sim's operation performed previously without benefit, and were afterwards dilated; two were dilated twice before a cure could be brought about. The history of several cases merits more than a mere allusion. The suffering of one of my patients had always been great at every monthly period, but while at boarding school they became so intense as to cause furious delirium at these times. This finally developed into permanent insanity, with suicidal impulses. While in this condition she was placed in my hands. After rapid dilatation of the cervical canal the dysmenorrhœa rapidly disappeared. The exemption from pain toned down some of her most extravagant delusions, but she did not wholly regain her reason until a few months afterward. She is now free from all menstrual pain and in the complete possession of her mental faculties.

A Hebrew lady whose health had suffered from dreadful dysmenorrhœa was improved so much at one sitting that her physician and friends were amazed. Not long afterward the former asked me to perform the same operation on another of his patients who was, if anything, worse. Her sufferings were so intense that he wrote, "I fear another period might

kill her," and urged an immediate operation." The cervix in this case was conical and very dense. Fearing a tearing of the parts. I screwed the instrument slowly to one and a quarter inches and kept up this amount of dilatation for some twenty minutes. The cervix sustained no injury. The canal has since remained patulous, and she is free from all menstrual pain.

Of the married patients, 53 were heard from; of these, 39 were cured, 10 improved, and 4 unimproved. Out of these 53 cases, 9 were not in a condition to conceive, 3 from fibroid tumors, 2 from destructive applications of nitrate of silver to a lacerated cervix, 3 from being over forty-one years of age, and 1 from being a widow. This leaves but 43 capable of conception, and of these 8, or a little over 18 percent., became pregnant. But the ratio is in fact larger, for several of my patients, fearing pregnancy, employed preventive measures after the operation. Then again, I believe that many who consulted me merely for painful menstruation have not reported their subsequent pregnancies. For instance two months ago by the merest accident I learned that the wife of a clergyman, whose cervical canal I dilated six years ago had been making up for lost time by giving birth to twins the first year after the operation, and later, to several other children. She had been married eight years before she came to me, and had had her cervical canal dilated by tents and slit up by Peaslee's metrotome by a skillful surgeon. I have also had several cases of pregnancy follow office dilatations of the uterine canal, in which ether was not given, and consequently the lumen of the canal was not much enlarged. But such slight operations were not deemed worthy of record, and they therefore have no statistical value.

Dr. Harris inquired about the danger of lighting up a former ovaritis by dilatation. The operation is successful, but that is its danger.

Dr. Goodell has not hesitated to operate, but always uses opium first, and by the time the operation is over, the patient is under its influence. He keeps them in bed and under the opium till all tenderness has passed entirely away.

Dr. Wm. Goodell exhibited a

DERMOID CYST OF THE RIGHT OVARY.

A saleswoman, aged 27, was obliged to give up her situation because she found herself unable to stand for any length of time. Her physician discovered a pelvic tumor and called in Dr. Goodell to see her. The diagnosis was obscure, but he leaned to a fibroid degeneration of the right ovary. The woman was otherwise well, suffering no pain whatever except when she was in the upright position. The operation was performed on September 8th, and the tumor turned out to be a dermoid cyst. Being enveloped in the broad ligament it was removed with difficulty. It is stuffed with hair, and contained a plate of bone, the sharp edge of which was readily felt per vaginam, but this threw no light on the diagnosis, as

it was mistaken for a fibroid spur. His patient did uniformly well and is now out of bed. He stated that in his experience these tumors are very vulnerable, and often resent even so slight an operation as aspiration, inflammation and suppuration quickly setting in. A physician had to-day brought to his office a young woman who had been tapped last June with a trocar. Long hairs and much sebaceous matter escaped through the opening, which had not yet healed up, and it was for this reason that he had been consulted. Upon passing in an uterine sound he struck a foreign body, which, from its density and the sharp click it gave, he was inclined to think was a tooth. He advised dilatation of the fistulous track and removal of the offending body.

TWO CASES OF OÖPHORECTOMY.

Dr. Goodell also exhibited the ovaries which he had removed on Sept. 17th and 29th from two patients, who were also doing well. He stated that the amount of tissue change in these ovaries was very slight, and yet the suffering of each patient was very great. One had been an invalid for several years, and bed ridden for the last six months. She had lost much flesh, and was always groaning from left ovarian pain, unless under the influence of large doses of morphia administered hypodermically. The left ovary was found to be undergoing cystic degeneration, but the right one was so sound that in its removal he was glad to have the backing of Prof. W. S. Playfair, of London, who was present at the operation. For he believed that in most cases needing oöphorectomy the results showed failure unless both ovaries were removed and the menopause established.

Convalescence after the operation had been retarded by great and painful swelling of the parotid glands, which had developed without any marked rise in the temperature, and without any acceleration of the pulse, and declined without suppuration, behaving exactly like mumps. This made his third case of parotitis following the removal of the ovaries. Not one had ended fatally, and from the very slight febrile movement, he thought that the complication was not symptomatic, as in blood poisoning, but sympathetic, and that a strong kinship, recognized by laymen, existed between the sexual organs and the cervical glands. Since the operation, all pelvic pain had ceased.

The other patient was a poor woman aged thirty, the mother of seven children. She was sent to him by Dr. Geo. H. Hull, of Chambersburg, Pa. Three years ago she began to suffer from double ovaralgia. The pain never left her wholly, but it began to increase in severity a week before the period, culminated during the flux, and faded off afterwards. Large doses of anodynes were also needed in this case, and she was unable to work. The case was clearly one of ovarian dysmenorrhea, and he believed she would be permanently cured.

Dr. Chas. H. Thomas asked Dr. Goodell his experience of the results of öophorectomy. What proportion of cases are relieved?

Dr. Goodell could not reply definitely. He intends to report his cases before this Society at some future time. In the majority of cases, menstruation ceases and that element of trouble being removed the patient is to that extent always improved. The neurasthenia resulting from previous suffering may remain, but it is far more amenable to treatment after the cause has been taken away. One such case has occurred to him recently. Dysmenorrhea caused a virtual insanity with a mind constantly wandering. The removal of the ovaries at once cured the dysmenorrhea. The patient is now able again to walk and the mind is improving. The operation removes the major element.

Dr. Thomas has now in his care, a case which he thinks typical. The patient is a literary woman, overworked and crushed by family anxieties and depressing emotions. He prescribed rest and feeding. Massage proved of but little use and electricity yielded negative results. Forced feeding became impossible. During menstruation she suffered for two or three hours with moderate dysmenorrhea. Signs of ovaritis developed with swelling and hardening in the right illiac region. The patient was etherized and a careful examination resulted in finding nothing materially wrong. As soon as anesthesia was complete all the induration and tumefaction disappeared. There was an ulcer of the rectum and moderate ante-flexion of the uterus. The ulcer has since been cured but there is no sensible relief. She suffers from a violent pain in the right ovary, extending to the coccyx and across the abdomen; it is cutting in its character at all times, and terribly severe. Formerly it ceased at night, but does not now. Hypodermic injections of morphia night and morning are necessary. Riding increases the pain which often extends down the right leg. She can not sit up long without increasing the pain, which is evidently getting worse day by day. She has been totally disabled for nearly ten months. Is this pain hysterical? Can it be relieved by öophorectomy?

Dr. Goodell remarked that öophorectomy is, in any case, a question requiring serious consideration. In the cases just related by him, the patients had neither the means nor the time for prolonged treatment. Whenever possible everything should be tried before resorting to an operation. One bed-ridden case under his care, very analagous to Dr. Thomas' had been relieved by the long continued use of the constant current passed through the affected ovary. A feeble current was kept up for many hours, sometimes for a whole night at a time. The patient ultimately got well, bore several children afterwards, and is now earning her living teaching.

OBSERVATIONS FROM THE STUDY OF 142 CASES OF HYSTERO-TRACHELORRHAPHY, BY CHARLES MEIGS WILSON, M. D.

Though much has been written on this subject in the past few years, I trust a description of special instruments, a summary of the histories of 142 cases will not be amiss. In view of the exhaustive treatment the

subject has received in the hands of many observers, I hesitate to report my own limited experience. One hundred and four of these cases occurred in the practice of Dr. E. Wilson, two in my own, and the balance I witnessed as assistant either in hospitals or private practice. I regret that circumstances prevented me from obtaining a full history in all the cases. No one should hesitate performing the operation or be unable to recognize the lesion. Yet very frequently gynecologists have sent to them either for an opinion or operation, cases diagnosed as eroding ulcers (fungoid vegetations), cancers, etc., which, when the patient is properly examined, prove to be cases of laceration. The touch alone is sufficient to establish the existence of the lesion. If corroborative evidence be required, the patient should be placed in the knee chest position, and the uterus exposed with a Sims speculum. For in this position if each everted lip is grasped with a tenaculum, by gentle manipulation the natural contour of the cervix can be restored. If this simple feat can be accomplished the diagnosis is at once established. For in malignant disease *ulcerations* of the os, etc., this can not be done. Reeves Jackson considers this test infallible. Formerly many cases of laceration were apprehended under the generic term, ulcers. But the description of the lesion and the operations by Dr. Emmet have settled forever the wellworn controversy which so long divided medical opinion, concerning the ætiology and pathology of the so-called ulcerations of the cervix uteri. Oftentimes useless injurious applications are made to the cervix, because the gentlemen having the medical care of the cases do not understand that the cervix is torn. The old-fashioned tubular speculum is still too frequently used. It is now generally conceded that it is useless except when *harsh* treatment is to be applied to the cervix without injury to the vagina. The tubular speculum separates the already everted lips and makes the laceration assume a more angry appearance. Thus faulty methods of examination often obscure the diagnosis. Another difficulty with many physicians is, that the symptoms of which the patient complains are too apt to be regarded as the expression of some malady, in which the uterus is not involved. Unless indeed they complain of some vaginal discharge (a condition rarely absent). Again the train of symptoms which belong to laceration, belong equally to many other uterine ailments, and nothing but a carefully conducted examination can demonstrate that such is the case. The anæmias, debility and other results of laceration, like the results of many other pathological conditions of the pelvic visceræ, are often treated by a course of tonics, whilst the underlying cause of all the mischief goes on with its destructive work. When a woman consults a physician, complaining of any of the more marked symptoms, such as cranial, rectal, vesical or pelvic pain, a feeling of weight about the uterus, disordered menstruation, and leucorrhœal discharge, a vaginal examination should be considered an "imperative and essential prerequisite to treatment,"

The best of investigation is always at hand, namely the index finger, which, says one of the masters of gynecic surgery, "when properly educated and used to the full extent of its capability, there is hardly any of the pathological conditions of the pelvic organs in woman, which can escape its detective powers." Simpson in England, and Gardner in this country, first called attention to lacerations of the cervix. Emmet, as he himself says in his books, accidentally discovered the lesion in 1862, and directed the operation for its relief. To him belongs the credit of revolutionizing gynecic surgery. Parturition is the chief cause of the lesion. The pressure of the child's head alone, especially if it be a large one, upon the os, may even in a normal labor be sufficient to lacerate it. If the os be rigid, or as frequently happens, be both rigid and attenuated, the danger is of course increased. If the longitudinal and oblique fibres of the uterus have greater contractile force than the circular fibres of the lower segment of the uterus have expansive power, the force of the contractions of the former exerted upon the fœtal body, which rests upon and is engaged with the latter, may lacerate them owing to their non-expansion. In premature labor, the circular fibres of the os not being ready for the dilatation necessary to permit the egress of the contents of the uterus, may give way, *i. e.*, there may be sufficient irritation of the uterus to expel its contents by contracting the fundus, but not enough to expand the os. Meddlesome midwifery is a prime cause. By which term I mean, the practice of trying to force back from the presenting portion of the child the margin of the os, without waiting for it to dilate properly, the desire to expedite the labor in every possible way, the premature rupture of the membranes, the physician forgetting that natures dilater the "bag of waters" is the best of all. Experience teaches that all labors in which the membranes have been ruptured prematurely, either accidentally or purposely, are apt to be complicated by some laceration of the obstetric curve, especially of the cervix. Unnecessary and unscientific application of the forceps, and tractions made with them without a proper knowledge of the pelvic curve and outlet is another factor. That the forceps are responsible for many cases of laceration, there can be no doubt. When applied high up, or within the uterus, they are exceedingly apt to produce tearing of the cervix. Observations made by Dr. Munde at the Mt. Sinai hospital, New York, showed 119 cases of laceration in 750 women examned. Dr. Hanks of the Demilt hospital found only eight per cent. troubled with laceration. The Mt. Sinai is a Jewish institution, and most of its patients Hebrews—these are generally attended by midwives. The The Demilt is patronized by the poor of the city generally, and the patients are mostly attended by young graduates, who frequently use the forceps. As far as these observations go they show that the forceps even in inexperienced hands do not do as much to produce laceration as the often untimely interference of ignorant midwives. Professor Gross in one

of the last papers he ever wrote, spoke of the frequency with which the forceps were applied, strongly condemning this practice and very justly attributing many of the cases of laceration of the cervix to it. He formulated his views in the words, "the principle causes of laceration are precipitate labor, labor attended with rigidity of the mouth of the womb and *instrumental* labor. Dr. Fundenberg in an article, which appeared in the *Pittsburg Medical Journal*, makes use of this positive language: "I believe that the forceps, when properly applied, is a prevention of laceration of the cervix.

When carefully introduced, for instance, into a rigid os, dilated only sufficiently to receive a narrow blade, the waters being discharged, it preserves the cervix by its inclined plane sudden impulse, imitating the bag of waters in its wedgelike and outward action, it dilates with great and continuous power, with any desired degree of slowness and with very great safety. In the 142 cases seen by the writer the forceps had been used in 49—presumably proves the account of the patients at the labor from which their distress dated. Did space permit I should like to quote from other papers in reference to this subject. Suffice it to say that the maladroit use of the forceps is responsible for many cases of laceration. The breech presentation is another factor, because of the necessity for a rapid delivery of the head. The cervix may also be torn by the shoulders after the head has passed safely through. The injurious practice of giving large and frequent doses of ergot prior to the delivery of the fetus is still another cause; so, too, are abortions. The predisposing causes include the various forms of induration, whether caused by hyperplastic deposit or malignant disease; all affections of the cervix producing tissue-softening, such as epithelioma; or any condition interfering with the natural elasticity of the part, as the cicatrices of previous surgical procedures, or as happened in two of the cases the writer saw, of cauterizations, and any syphilitic or strumous taint giving the uterus lack of tone. Dr. E. Wilson lays great stress on the "muscular depravity, the result of a constitutional syphilitic taint, and the consequent emaciated condition of the os. This muscular degeneration way be the result of many pathological conditions, for example, anæmia, malnutrition, phthisis, or the like. Again, when the uterus is in a state of constant activity owing to frequent gestation, it is liable to lose tone and thus pave the way for the exciting cause to light up the trouble. Women are more apt to meet with this trouble at their first delivery than subsequently. It occurs more frequently in rapid labors. Dr. Emmet believes that partial laceration occurs at the first labor. Drs. Goodell, Pallen and Mundé all record it as exceedingly common. In two hundred cases of uterine disease examined by the author, nineteen had laceration of the cervix. The lacerations may extend through any portion of either lip. The writer has found the bilateral to be the most common, the rent being greater upon the left side, and laceration through

the posterior lip the rarest form. The fact that a laceration has taken place is seldom noticed at the time of its occurrence. When an examination is made at the completion of delivery, the parts are so enlarged, soft and yielding, and the os so patulous, that it is difficult to detect a laceration. But if a tear has occurred the woman soon begins to complain of symptoms which are well nigh pathognomonic. Shortly after rising from her bed and resuming her ordinary household duties, she notices a more or less contant and generally increasing leucorrhœal discharge, at first viscid and glairy, and sometiwes tinged with blood. This discharge is rarely absent, and seldom disappears spontaneously after a short time. Dull acheing pains, generally referred to the lumbar region is a prominent feature. Headache is a marked symptom. There is a peculiar sense of weight which is increased, along with the pain, on exertion, and on assuming the erect posture for some time. The menstrual flow is commonly increased in quantity, frequency and duration, and sometimes during the periods there is a nasty glairy discharge. The general health soon becomes impaired, there is malaise, the digestive system being commonly the first to suffer. Sexual appetite is usually impaired, sometimes abolished, and its gratification always attended with great pain. Insomnia is often present together with other symptoms of a nervous character. The writer has seen one case in which hystero-catalepsy is a prominent symptom. The symptoms are generally commensurate with the extent of the eversion of the lining membrane of the cervical canal. This membrane when thus exposed loses its delicate epithelial coat, and it chafes against the posterior wall of the vagina, irritating and inflaming the raw surfaces, and hypostatic congestion and engorgement ensue. This prevents the proper involution of the uterus and the parts remain large and soft. The heavy uterus, no longer sustained by its supports, falls to the floor of the pelvis, dragging the upper portion of the vagina with it. This makes the cervix appear lengthened, when in reality it is shortened. Sometimes cicatrization takes place, and often this plug of cicatricial tissue gives rise to symptoms more distressing than when the parts remain ununited. The mental symptoms are sometimes very grave, even threatening the sanity of the patient. One of Dr. E. Wilson's patients was for some months in an insane asylum. After her cervix was restored her symptoms gradually subsided, and in six weeks entirely disappeared. This woman was deprived of her liberty because her friends refused to have the operation done. Another woman in his practice, a subject of melancholia with uterine symptoms, came very near being spayed. After her cervix was restored her melancholy and other symptoms vanished entirely. A very curious case of persistent salivation apparently due to a laceration, which was cured by restoring the cervix, is reported by Dr. Longyear.

If the foregoing views in reference to laceration are correct, the indications for treatment are clear. The surgeon must consider whether the

patient is in a proper state of health to operate. When the uterus is bound down by adhesions, or when severe inflammation exists, it is danerous to operate. One case which came under my observation nearly perished from peritonitis, because forcible traction was made to draw down to the ostium vaginæ a uterus which was fixed and immobile owing to adhessions the result of a former peritonitis.

For operating the patient should be placed in the dorsal position, with her buttocks well drawn down to the edge of the table, an assistant taking charge of each limb. The cervix is exposed with a Sims' speculum, grasped with a volsella, and gently brought to the osteum vaginæ. The needle is passed through the cervix in the median line from above dwonwards, then armed with a stout piece of silk cord and withdrawn. A blunt pointed tenaculum is then passed up the cervical canal until it engages the cord, a loop of which is withdrawn, divided, and united to each free end, thus forming two loops, the one controlling the anterior, the other the posterior lip. The margins of the tear are now freshened, care being taken to extend the incision beyond the angle of the rent, and to cut out any cicatricial tissue which may be present. The hemorrhage, which is never very profuse, and which by depleting the vessels of the uterus tends to ameliorate the inflammatory condition often present, is easily controlled by the application of hot sponges. Anyone who has seen many operations must have noticed the sudden blanching and softening of the cervix due to the bleeding attending the operation. The late Professor Gross thought that the benefit of the operation was largely due to the local depletion. I have seen the circumflex artery cut on several occasions, but it never required a ligature to control it. Care should be taken to make the posterior angle of the plug of tissue removed sufficiently acute to allow of the proper approximation of the lips without tension on the suture. The lower lip should be denuded first, otherwise the hemorrage will obscure the field. Sufficient mucous membrane should be reserved in the center to reform the canal. This is not always possible, and when it cannot be done, a small piece of carbolized lint should be inserted to prevent union in the line of the canal. This should be removed at the end of twenty-four hours, otherwise the canal might be occluded. This accident happened in three of the cases of Dr. E. Wilson's series, and the occlusion was overcome with some difficulty. All the clots having been removed and exact hæmostasis having been maintained for some moments, the wound is closed by inserting the needle through both lips, arming it with a wire suture, withdrawing it, freeing the wire and clamping it with a shot. The ends are then cut off close to the shot. The sutures should be removed by the 10th day. As they are difficult to get off, these scissors were devised for that purpose. The vagina should be syringed twice daily with a solution of the mercuric bichloride 1-2000. A Sims' speculum should be used to remove the stitches, as there is danger of tearing the freshly

united surfaces apart with a bivalve. In these cases I have seen excessive bleeding occurring on the third day after operation. This, however, did not seem to come from the wound, but was regarded as the result of the passive congestion of the endometrium. If the operation is successful, the relief afforded is speedy and sure and generally permanent. The operation is simple and free from danger. It often renders sterile women capable of child-bearing. Dr. E. Wilson has confined ten women in whom he had previously performed the operation. In two there was a slight recurrence of the tear. In many cases where coitus was impossible on account of the pain and hemorrhage it produced, the difficulty has been overcome. In one case only did the operator fail to get a satisfactory result. The cervix was badly torn; it was repaired; the woman was afterward found to have salpingitis. Though her health was improved after the restoration of the cervix, she did not recover. In a future communication to the Society I hope to show her fallopian tubes.

Allowed to run its course, the sequelæ of laceration are endless: disturbances of the catamenia, dysparunia, ovaritis, leucorrhœa, subinvolution, grave mental disturbances, and above all, epithelioma. In conclusion, gentlemen, permit me to quote the words of an eminent gynæcologist: "These are not the chimeras and hobbies of the specialist, but grave and serious dangers." It is to be hoped that in time to come a more certain and scientific knowledge of the dangers and difficulties of parturition and the methods for their avoidance may enable the physician to avert this troublesome accident.

Dr. Baer inquired if the operations were done for the relief of sterility.

Dr. Wilson replied that they were for the relief of general symptoms. Ten of his cases have since become pregnant.

Dr. Goodell remarked that he had no trouble in removing the stitches. His method was to leave the two upper lateral stitches with long-shotted ends; by means of these each side of the cervix can be drawn into the middle of the field of the bivalve speculum, and the stitches removed with ease.

Dr. Montgomery bore testimony to the same, and to the value of the bivalve speculum over Sims' for that purpose. He had used the double thread through the cervix, and had described its uses before the Society at the meeting of October 6, 1881, and published in full in the OBSTETRIC GAZETTE for January, 1882. As regards the quantity of tissue to be removed in closing a laceration, the operator must be governed by the character of the injury, and it might be possible to have a satisfactory result where there was anteversion of the uterus, the flexion occurring in the lower part of the cervix, the anterior lip being elongated and hypertrophied, the posterior normal or even atrophied; for in such cases it was impossible to prevent the preponderance of tissue in the enlarged lip. He could readily understand that such a uterus becoming pregnant, in a sub-

sequent labor the long anterior lip would form a segment over the child's head, which would almost certainly result in relaceration. In the case which Dr. Wilson cites, of extensive laceration during labor, the proper treatment would have been to perform a primary operation by the immediate introduction of sutures, rather than permit her to be subjected to the necessity of a secondary operation. It would be necessary to introduce the sutures much deeper, and then make allowance for the subsequent involution.

It is not infrequent that multiple lacerations resemble epitheliomatous disease, and are accompanied by offensive discharge. He had given temporary relief in such a case by the use of chromic acid and tannin locally. The needle used in passing sutures should not be much larger than the wire that is to follow it.

Dr. Wilson questioned the propriety of primary operations on the cervix.

Dr. Montgomery said that the first case by Montrose Pallen was a primary operation, and was successful.

Dr. Charles H. Thomas remarked that at the meeting of the Society on October 6, 1881, he had reported "A Case of Laceration of the Cervix Uteri Simulating Cauliflower Excresence," which he had treated eighteen years before. The patient was exsanguine from hemorrhage which had put her life in great danger. He used glycerole of tannin tampons, and at the end of two weeks she had improved immensely, and the condition finally proved to be a deep laceration with ectropion. Before the treatment she had been seen by six experienced gynecologists who declared the condition cancerous, and one of them refused to be convinced that it was not so, saying within the past four years that "it had been cancer, it was cancer, and she would die of cancer." When the case was reported, one of the physicians who had originally seen the case inquired of Dr. Thomas if he "proposed to cure uterine cancer by means of glycerole of tannin tampons." The menopause has since been established, the uterus, examined within the past month, was found atrophied, and the former patient has been for nearly twenty years a hard-working monthly nurse.

Dr. Goodell thinks it pardonable to make the mistake. With all his experience he had seen two cases in which he could not for some time make a certain diagnosis. There was no doubt about the existence of a laceration, but whether the angry-locking growths were merely cock's-comb granulations or epithelioma was not so easy to decide. They eventually proved to be benign.

Fish as an Article of Food.—Prof. W. O. Atwater, in a paper on the chemistry of fish, contended that it had been shown that fish was as readily digested as flesh meat. Oysters, however, he regarded as far less nutritious than fish.

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(Continued from our last issue.)

Section of Obstetrics and Gynæcology.

Antiseptics in Laparotomy.

Prof. Miculicz of Cracow began by referring to the necessity of antiseptics in laparotomy, as well as in all other operations attended with loss of much blood. The principles for the use of antiseptics in laparotomy are the same as in other great operations, but the details differ in some points. This depends on the peculiarity of the peritoneum, which in some respects favored, but in other respects impeded, the application of antiseptics. The most important properties of the peritoneum having an influence on antisepsis were, first, the great extent of surface, which was a soure of danger from cooling on exposure, of rapidly spreading inflammatory and septic processes, etc.; second, its greater power of absorption and exudation, the first leading in septic peritonitis to general septic infection, while in the healthy peritoneum it prevented the accumulation of large masses of secretion; thirdly, the liability to pour out plastic exudations, and to rapidly form firm adhesions; in this way foci of inflammation might be localized, and ligatures and separated masses of tissue encapsulated.

With regard to antisepsis in laparotomy, attention was directed to the following points: A. The peritoneum is more easily affected by septic infective matter than any other tissue, besides this, it is not possible to use, as in wounds of other parts, very active antiseptic measures, such as irrigation with carbolic acid, as, on account of rapid absorption, the danger of poisoning by the antiseptic is very great. Again, while drainage was useful in other parts of the body, it was useless in the peritoneal cavity, and could not obviate the results of infection of any kind. For these reasons the chief point to be attended to in antisepsis during laparotomy is the complete withholding of all septic matters from the peritoneum, and here lay the great difference between antisepsis in laparotomy and in other operations. In laparotomy antisepsis was prophylactic, and more thorough than in other operations. Spray was superfluous in faultlessly clean rooms, but in hospitals it should be used for an hour before the operation to purify the air. Absolute prevention of the escape of the intestinal and gastric contents was an important point in antisepsis. Drainage of the peritoneum was commonly superfluous in operations performed antiseptically. It might even allow infection to occur through the drainage-openings. Complete drainage is, on mechanical grounds, impossible; hence drainage is permissible only in rare and exceptional cases of laparotomy.

B. Besides direct infection during the operation, spontaneous infection might occur in the peritoneum in certain conditions, as when serous fluid in the cavity of the peritoneum was not absorbed, but developed bacteria,

Hence the second great principle of antisepsis was to prevent collection of secretion in the peritoneal cavity. Among measures to this end were, the "peritoneal toilet," the prevention of secreting wound surfaces by ligature *en masse*, cauterization of the pedicle and adhesions, suture of the wounded surfaces; and the shelling out of tumors having a wide base or lying behind the peritoneum. To favor absorption a compress should be applied over the whole abdomen.

THE SIGNIFICANCE OF ALBUMINURIA IN PREGNANT WOMEN.

Prof. Halbertsma (Utrecht), in a paper on this subject, said, in the first place, that the facts observed did not permit his recognizing, as the cause of albuminuria in pregnant women, a reflex contraction of the renal arteries. Secondly, albuminuria in pregnant women was specially observed when there was want of proportion between the size of the gravid uterus and the abdominal cavity. And, thirdly, the cause of albuminuria in pregnant women was, in the greater number of cases, tension and compression of the uterus.

SOME DIAGNOSTIC DIFFICULTIES CAUSED BY HYPERTROPHY OF THE CERVIX UTERI.

Prof. Howitz (Copenhagen) pointed out that, in cases of hypertrophy of the neck complicated by dilatation of the body and fundus of the uterus, special symptoms arose in consequence of change of the anatomical relations. In cases of pregnancy, especially in the first months, this condition gave rise to diagnostic difficulties. The elevated situation of the uterine enlargement, its strange mobility, its elasticity and situation, were characteristic guides in such cases. The fetal *bruit* could also be heard sooner than ordinary. A careful examination by the vagina and rectum would give precise information as to the exact condition of the uterus.

Dr. Priestley (London) said he had seen cases very analogous to those described by Prof. Howitz, which produced, not difficulty in diagnosis, but difficulty in accouchement. It was a question well deserving of consideration, whether, in certain cases, some operative measure might not be adopted.

THE OPERATIVE TREATMENT OF EXTRA-UTERINE PREGNANCY.

Professor Werth (Kiel) said that the operation was indicated in the early months of pregnancy when the fœtus, being dead and lying in Douglas' pouch, produced severe symptoms of incarceration. On the other hand, laparotomy was without object when it was concluded that rupture of the sac had taken place, and experience up to the present time was in favor of expectant treatment. When pregnancy was more advanced, and the embryo was alive, operation gave little prospect of saving the child, and was of unfavorable prognosis for the mother, except in cases where the anatomical conditions favored removal of the entire ovum with its membranes. Hence it was a principle to avoid operation while the child

was alive, and to wait for its death. The expulsive movements following the death of the embryo could, as a rule, be held in check by appropriate means. As the extra-uterine position of a fœtus which had died after having passed beyond the first stages of development was a source of danger to the mother's life, removal by operation of the dead fœtus was necessary. The prognosis was incomparably better than that of operation during the life of the fœtus, provided that a suitable time were chosen for the operation. This, whenever possible, should not be performed before arrest of the circulation in the maternal placenta might be supposed to have taken place; namely, from the tenth to the twelfth week after the death of the fœtus. Speaking of the methods of operation, Dr. Werth said that, in the rare cases of prolonged pregnancy in the outer part of the Fallopian tube or in the ovary, with simultaneous unfolding of the broad ligament, extirpation of the entire sac was indicated; the operation was like ovariotomy, and the prognosis was similar. As a general rule, the sac should be sutured to the abdominal wound. The placenta and membranes of the ovum should be removed, if there was no doubt as to the previous occlusion of the placental sinuses by thrombosis. If strict antiseptic precautions were followed during the operation, and an occlusive dressing applied, then neither preventive drainage through the vagina, nor permanent irrigation of the sac, was necessary, provided that decomposition of the contents of the sac had not already set in. Both these were to be avoided, as well as washing out and plugging the sac, when the operation was performed during the life of the embryo or shortly after its death, and when artificial or spontaneous detachment of the placenta threatened fatal hæmorrhage. On the other hand, the author recommended in these circumstances the partial filling of the fœtal sac with some substance (tannin and salicylic acid in equal proportions, according to Freund), which might enable the placenta to remain aseptic until it was thrown off at a later date. Elytrotomy was preferable to gastrostomy only in some rare and peculiar cases. With regard to the proceeding recommended by Martin, of partial removal of the fœtal sac, suture of the remaining part, and drainage through the vagina, further experience was required before a decision could be arrived at as to its general applicability.

The Early Performance of Ovariotomy.

Mr. *Knowsley Thornton* (London) read a paper on this subject. He first considered whether it was ever right to interfere with an ovarian tumor by tapping or by aspiration. Spencer Wells, Keith, and Thomas were in favor of tapping; and many other leading ovariotomists encouraged it. He gave quotations from Gross, Emmet, and Lawson Tait against the practice; and referred to the doubtful advantages claimed for this proceeding compared with its dangers, and its immediate and remote mortality. He said that exploratory incision was far safer and better in

doubtful cases. Tapping should be condemned, except in some very rare cases. He would always remove an ovarion tumor as soon as it was large enough to be abdominal and slightly stretch the parietes. There were objections to operating earlier, except in special cases. The danger lay in delay. Pathological changes in the cysts might lead to the escape of their contents, and to the formation of adhesions; or the pedicle might become twisted. He adduced illustrations of the dangers of delay, drawn from over four hundred ovariotomies he had performed, including forty cases in which ovarian fluid was free in the peritoneum, and thirty-four cases of twisted pedicle. He then summed up by considering the following questions. 1. Is tapping ovarian or parovarian cysts, or cysts of the broad ligament, ever justifiable; and if so, what conditions justify it? 2. Can any fairly general and defined rule be laid down as to the proper time at which to perform ovariotomy; and if so, what conditions justify an earlier or later operation? He concluded by appealing to the profession to still further improve the brilliant results of ovariotomy, by condemning tapping and supporting early ovariotomy.

MANAGEMENT OF THE THIRD STAGE OF LABOR.

Professor Stadtfeldt (Copenhagen) read a paper in which he gave the result of the expectant method of treatment, Credé's method, and the Dublin method. In the expectant method, as practised in Copenhagen, the placenta was allowed to become detached spontaneously, and to escape into the vagina, unless severe hæmorrhage indicated earlier removal of the contents of the uterus. As a rule, the detachment of the placenta took place within about two hours. In Credé's method, circular frictions of the fundus uteri were made immediately after the birth of the child, and during a strong after-pain, generally the third, the placenta was pressed out by a combined concentric and pushing down pressure on the fundus and body of the uterus. The Dublin method was described in somewhat different terms by different authors. As a rule, the chief importance was attached to pressure on the fundus uteri immediately after the birth of the child. This, he thought, tended to increase anteflexion, and thereby to impede the escape of the placenta. He had, therefore, applied friction to the fundus uteri, as in the first stage of Credé's method; and, when the placenta had escaped into the vagina, it was easily removed by the help of two fingers, with simultaneous gentle traction on the umbilical cord. In a few cases, where the placenta was not expelled at the end of half an hour, he made a depressing movement through the fundus. When these methods failed, the placenta was removed by the introduction of the hand into the uterus. Dr. Stadtfeldt had treated a large number of cases by each of the three methods above named, and gave the results. From his statistics he excluded all cases of abortion and of placenta prævia, cases in which the contents of the uterus was putrid, and some cases of very difficult labor. From April 1st, 1873, to

March 31, 1877, he followed the expectant method in 1,780 cases; from September 1st, 1877, to February 1st, 1881, Credé's method in 1,611 cases; from May 12th, 1882, to February 15th, 1884, the Dublin method in 971 cases; and from February 16th to May 30th, 1881, the expectant method in 198 cases. The results indicated that, when compared with the expectant method, that of Crede was preferable. Detachment and retention of the membranes, or of small portions of placenta, indeed occurred more frequently; but the preponderance was not great (2.3 against 1.8 per cent.), and any danger might be obviated by the use of antiseptics. On the whole, it seemed to him that the objectors to Crede's method were wrong in attaching too much importance to its disadvantages, and in overlooking the fact that it removed the dangers attendant on the expectant method during the time of waiting, especially outside lying-in hospitals. It could not, however, be denied that the proper and safe application of Crede's method required so much intelligence and accuracy, that it might be attended with danger in the hands of unskilful persons, and, therefore, it was not thought right in Copenhagen to teach it to midwives. On the contrary, the Dublin method was easily learnt, and was free from the dangers of the expectant and Crede's methods; on the one hand, it diminished that liability to flooding and of retention of the placenta; and, on the other, removed the danger of separation and retention of the membranes. It had been said that Crede's method, by favoring retention of the membranes and of the decidua, was more liable than the expectant method to give rise to puerperal disease and mortality. The contrary was the result in Dr. Stadtfeldt's experience; the figures given being, with the expectant method, for disease, 24 per cent., and for mortality, 1.9; with Crede's method, disease, 18.3 per cent., mortality, 0.6 per cent. In both series, antiseptics had been used with equal energy. He believed that, in the present day, retention of the membranes had little influence on puerperal disease and mortality, provided that strict antiseptic precautions were carried out during labor, and that the accoucheur abstained from unnecessary meddling during the lying-in period. Large portions of decidua might even be left in the uterus without becoming septic, and without giving rise to self-infection of the patient.

Congenital Lateropositions of the Uterus, Etc.

Professor Lazarevitch (Kharkoff) addressed the Section on the congenital lateral positions of the uterus in their relation to the mechanism of labor, and to the peri-uterine tumors. These congenital lateral positions were, he said, frequent, especially those in which the uterus was completely displaced to the left. Those which depended on the development of pathological growths must be changed to other positions, and on that account must be called accidental. But, if they depended on a defect in the development of the broad ligament, or of the lateral wall of the vagina, these positions were invariable, and did not alter during the growth of

the tumors, whatever these might be, which were formed round the uterus, any more than during the period of pregnancy. If the lateral position of the uterus were sufficiently marked, the anterior position of the recto-uterine pouch, being displaced by the uterus, took an oblique shape; and the ovary, which corresponded to the large side of the peri-uterine space, being pressed upon, often lay above the periuterine pouch, and fell down more or less. The ovary of the opposite side, not finding place near the uterus, was ordinarily raised up and passed above the upper entrance to the cavity. According as the one or the other ovary became cystic, the cyst either remained for a longer or shorter time in the deep cavity, and, in its growth, displaced the uterus forwards and upwards, or, from the beginning of the growth, was found above the deep pelvis and the uterus, leaving it free. If the ovary corresponding to the large side of the peri-uterine space became cystic, the pedicle of the cyst was ordinarily long; and, on the contrary, it was short if the cyst belonged to the ovary on the smaller side of the peri-uterine space. Thus, so far as the lateral position of the uterus was concerned, one was not able to say to which of the ovaries the cyst belonged; but, if one knew to which ovary the cyst belonged, one could estimate the length of the pedicle. Being turned to one side, the uterus left free entrance to the recto-uterine pouch; and, for this reason, the blood of the pouch could spread in all directions. If the uterus were turned to one side, it was difficult to say that it was completely inclined, or bent forwards or backwards; it was in this event that the cases of latero-version and latero-flexion were met with. In the case where the uterus was turned to one side, pessaries could not keep it up, owing to the difference in the length of the lateral walls, and the difference in height of the lateral vaults of the vagina. One was often deceived as to the origin of the pain felt sometimes on one side in the lower part of the abdomen, particularly during menstruation, in attributing this to the ovary. This pain most often proceeded from the laterally displaced womb. Congenital lateral positions, as well as the lateral versions of the womb, had an evident influence on the mechanism of labor, but this influence was not proportional. In the lateral version the womb, increasing during pregnancy, preserved its regular form, changing only the direction of its axis; whereas, when displaced in the lateral position, it preserved the direction of its axis, but changed its shape because, on the side on which it approached one of the lateral walls of the pelvis, its lower segment did not expand, or expanded very little, whilst the segment on the opposite side underwent sacciform expansion. During labor, one could easily do away with the lateral version of the womb by making the woman assume a suitable position, or by keeping up, by means of the hands, the corresponding side of the womb. But these measures became useless if the womb were in the state of lateral position. In this case, it was enough

to introduce the finger into the neck of the uterus, and to draw it towards the middle of the pelvis.

Statistics of Puerperal Fever in Denmark.

Dr. E. Ingersley (Copenhagen) read a paper, in which he gave a brief summary of a research into puerperal mortality in the towns of the Danish provinces and in Copenhagen for the last seventeen years. The principal aim of the paper was to explain how the difference between the mortality in the maternities and outside of them, elsewhere brought into such strong relief, had lost its *raison d'etre* since it was proved that the antiseptic measures to be taken in labor were still less performed outside maternities. He also stated his opinion that matters were, up to this time, nearly as successfully managed in the towns as in the country districts of Denmark. Dr. Ingersley went on to show the ravages of puerperal fever were most manifest when one looked at the proportion between the puerperal mortality and the total mortality in women from 15 to 45 years of age, that was to say, of the age at which labor generally took place. In this regard, a great resemblance was found between this and like researches made a short time back in Prussia. The great difficulties in the way of finding a fairly exact expression for the puerperal mortality would be, perhaps, best overcome in a small country, where one could almost easily obtain a general view of things, and make requisite corrections by applying to medical men for the necessary explanations. He had made the attempt for a period of some years, and in this way had made a calculation of the mortality as near as possible, and showing, at the same time, a minimum of errors. The calculation, so checked, showed an evident decrease in the puerperal mortality, which undoubtedly was due to a more strictly antiseptic conduct of labors even outside the maternities.

Uterine Adenolymphangitis.

Dr. Martineau (Paris) read a paper on the above condition as a cause of the so-called peri uterine troubles, and its importance in the treatment of inflammation of the uterus. He took the view that the uterine and peri-uterine adenolymphangitis was closely connected with uterine inflammation. Acute or chronic metritis could not exist without the uterine and peri-uterine lymphatic system sharing in the inflammation of the uterine tissue. Peri-uterine adeno-lymphangitis was the origin of the inflammatory accidents called peri-uterine, such as phlegmon of the broad ligament, peri-uterine phlegmon, perimetritis, and pelvic peritonitis. The designation of these conditions by the names adeno phlegmon of the broad ligament, peri-uterine adeno-phlegmon, adeno-pelvic peritonitis, was that which suited them, because it recalled their origin and pathology. Peri-uterine adenolymphangitis being equivalent to uterine inflammation, every cause which would have as a result the increasing of this inflammation would at the same time increase the peri-uterine adenolymphangitis, and bring about the symptoms.

A New Electric Treatment of Perimetritis.

Dr. Apostoli (Paris) proposed "a new electric treatment of perimetritis by double faradization of the uterus." He described in the first place the modification which he had introduced in the manual application of uterine faridization (A. Trifner's method), and he enumerated its general advantages in the treatment of simple metritis. He applied his method advantageously also in perimetritis, and described the manual method, the dose, duration and intensity of the application. Summing up, he had always found faradic currents of high tension, feeble dose and long duration to relieve every perimetritis, and bring about its rapid resolution.

Partial Excision of the Peritoneum.

Dr. Saenger (Leipsic) said that in the radical extirpation of large dermoid tumors of the abdominal wall (fibroma, sarcoma, perhaps myoma) which, arising mostly from the aponeuroses, were closely or even inseparably connected with the parietal peritoneum. This might require to be cut away along with large portions of the abdominal muscles, to such an extent that the edges of the peritoneal wound could not be brought together, and no covering remained except the skin. Dr. Saenger had operated on a case by a modification of Sklifosovsky's operation, and the course had been perfectly aseptic. The abdominal muscles, which were much thinned, being preserved, the swelling was removed from its capsule with a portion of parietal peritoneum, a number of small drainage tubes were placed in the abdominal cavity, the skin was drawn together and sutured in such a way as to form a firm ridge, so as to prevent the occurrence of a hernia. Excision of the abdominal wall might be followed by retroperitoneal emphysema, which might be removed in a few hours by the application of an elastic bandage. Experiments on rabbits showed that a new formation of peritoneum does not take place, but the intestine rapidly becomes adherent to the skin. Resection of the parietal peritoneum and of that in Douglas' pouch, the author said, might be done in cases of firm adhesions of tumors of the abdominal cavity, where the breaking through of close and very vascular tumors appeared likely to be very difficult, and also in cases where the peritoneum, mistaken for an adherent capsule, had been extensively peeled off from the aponeurosis, and the peritoneal space converted into a sac which might readily become the seat of an abscess.

Treatment of Puerperal Fever by Cold Baths.

Prof. Vincent (Lyons) said, 1, that the administration of cold baths was practicable with the recently delivered attacked with puerperal fever.

2. That cold baths are free from danger in the puerperal state.

3. They have a certain and quick antifebrile effect in the sequelæ of delivery.

4. Recovery from puerperal fever was the rule with treatment by baths of proper temperature and methodically administered.

5. Cold baths were indicated in all high temperature forms of after complications of childbirth, the very acute peritonitis excepted. The indications for cold baths did not arise except where the fever had been kept up, without notable morning remissions, to about 40° Cent., when the powerlessness of quinine and diffusable stimulants in full doses had been shown, and when the lochia were fœtid and intrauterine injections had been carefully tried without bringing a fall in the febrile condition.

6. Cold baths should be given at a temperature varying from 28° to 18° Cent.; according to the fall secured by the first bath at a temperature of 18° to 36°, the temperature of the subsequent bath should be reduced. (The rule was to get with a cold or tepid bath a fall of one or two degrees in the patient's temperature.) The method used in typhoid fever treated by the system of Dr. Brand, should be used, with modifications.

7. The cold baths were repeated every three hours, until the temperature had fallen to 38° C., and stayed there, with only oscillations of some tenths in the evening.

8. When baths of 18° or 20° Cent., repeated every three hours, night and day, did not bring about a notable reduction of temperature, a large ice bag should be placed in the intervals between the baths upon the abdomen of the patient.

9. Along with cold baths and ice bags, spirits and tonics should be freely administered. The patients should be fed with liquid and semi-liquid foods having much nutriment in small bulk — soups, beef tea, American broth, milk, etc.

Dr. Gordon read a paper on Operative Treatment for Hyperplasia of the Uterus and Vagina, with special reference to Cure of Displacements.

Dr. Marcy (Boston) advocated restoration of the perineum by a new method, and Dr. Zambaco (Constantinople) submitted to the section some Physiological and Pathological Remarks upon the Women of the East.

OBSTETRICAL SOCIETY OF BOSTON.

Meeting of May 10th, 1884.

DR. C. ELLERY STEDMAN, President, in the chair.

GASTRO-NEPHRIC FISTULA.

Brief notes of a case of this extremely rare lesion were read by Dr. J. R. Chadwick, who reserved a full report until the case should be made complete by an autopsy.

A married lady, sixty-two years of age, had had attacks of gastric colic, with vomiting, at intervals of one to six weeks for seven years. She had had frequent micturition for a year and a half, and had seen particles of food in her urine. She entered his private hospital on November 12th, 1883, when the abdomen was found to be generally tympanitic, except in

the upper part of the right lumbar region, where a resisting, tender body was felt protruding from beneath the ribs like an enlarged kidney. Turbid urine was drawn from the bladder, the flow being occasionally interrupted by solid particles and by bubbles of gas. This urine was found by Prof. E. S. Wood to contain a "trace of albumen, much pus, a little blood, muscular fibre, boiled potato, vegetable fibre." The examinations of the urine were made for many consecutive days by Professor Wood with essentially the same results. As the attacks of colic were apparently confined to the stomach, as the tumor was in the region of the right kidney, as the particles of food found in the urine were invariably undigested, and above all as no trace of bile was found in the urine, except for three days following an attack of vomiting, the diagnosis of gastro-nephric fistula was thought warrantable. This was accepted by Drs. G. H. Lyman and C. E. Stedman, who saw the patient in consultation. Various diets were tried without effect, so that after a month the patient was sent home to Rhode Island unrelieved, as her condition did not warrant a resort to the very hazardous chances of an operation. Dr. Chadwick had found in medical literature the reports of but two authentic cases of this lesion; one in a French thesis of 1856, where a gastro-nephric fistula had been discovered post mortem, but no history of its course recorded; the other in an Italian journal published in 1866, where no confirmation of the diagnosis by autopsy had been reached at the time of publication. The probable origin of these lesions is in purulent nephritis.

Dr. Lyman said the case was one of the most interesting that he had ever seen; it was wonderful that the woman had maintained her nutrition so well. He inquired if the woman had been fed by rectum.

Dr. Chadwick replied that she had not. It was found that liquid food given by stomach escaped without much change through the bladder; hence it was thought best to give solid food which remained longer in the stomach. At one time there was much gas discharged by the bladder.

Dr. Abbot asked if the urine had been examined at times of long abstinence from food, and compared with the urine passed soon after taking food, with a view to determining whether the fistula was gastro- or intestino-nephric. The reply was that no such experiment had been tried.

CRANIAL BONES OF A FŒTUS REMOVED FROM THE RECTUM.

Dr. Doe reported the case and showed the specimen.

E. W., colored, widow, fifty-two years of age, entered the City Hospital on April 8th last, complaining only of diarrhœa. Her discharges averaged about seven in number daily and were very thin and often slightly bloody. Under the use of astringents she had but one daily, and after having been kept in bed for two weeks she was allowed to sit up. On doing so, she stated that a very full watery discharge from the rectum took place, and she had no voluntary control of the sphincter. The nurse was directed to give a laudanum injection, but found it impossible to in-

troduce the syringe, as it seemed to impinge against a hard substance just inside the anus. My assistant, Dr. Welch, was called, and found that the obstruction was caused by a collection of small bones, one of which was removed and found to be the left temporal bone of a fœtus. By questioning her closely the following history was obtained, though she seemed somewhat unreliable in respect to dates:—

She had borne three children, the last thirteen years ago: her labors were not difficult. Ten years ago she had a miscarriage when about four months pregnant; but, as the only thing that came away resembled a piece of liver, she was not sure that it was a miscarriage. Since then her catamenia have been regular, until their cessation five years ago. About six months ago something rather hard, about the size of an orange, passed through the rectum. Since then she has had a diarrhœa, the discharges at first being accompanied with pain and containing crumly matter. The dejections during the last two months have occurred sometimes as often as every fifteen minutes, and frequently have taken place involuntarily during sleep; they were very much less frequent when the patient was in bed. During the past two months there has been considerable abdominal pain and rectal pain, which would be relieved by defecation. The day before entering the hospital she passed two pieces of bone from the rectum; one resembling half a wish-bone; and the other, the upper part of a chicken's leg. When the patient first entered the hospital examination of the abdomen revealed nothing abnormal. There was some emaciation, but not as much as one should expect to arise from a diarrhœa of six months' duration. On the day when she had the large involuntary discharge on sitting up there were noticed hard masses in the left inguinal region, which moved under the fingers, and also a large tumor above the pubes, which proved to be an over-distended bladder. The patient then stated that she had passed urine only at intervals of three days during the past three months, feeling no inclination to pass it oftener. In removing the bones four of the largest ones were found in close juxtaposition about an inch inside of the anus; they were quite freely movable, and as the sphincter very readily dilated, they were removed with but little difficulty. Three fingers could be easily introduced into the rectum, and but little, if any, laceration of the sphincter resulted. After removal of the bones near the anus another collection was found closely imbedded together, directly underneath the promontory of the sacrum. There was much more difficulty in removing them, especially the first one, and in their removal a considerable amount of a thick cheesy deposit was noticed. The fingers could not recognize any distinct rectum, but high up seemed to enter a large sac containing the bones, the walls of which seemed to be defined by a thick cretaceous deposit.

The bones were removed fifteen days ago, and since then the patient has had no unfavorable symptom. The temperature was 100° F. the day

following the operation, and since then normal. She is now sitting up and has on an average two dejections daily, lately well formed. The sphincter shows no signs of any laceration having been produced; but the rectum is still very capacious and not easily defined, the finger apparently entering a large cavity with soft, cheesy-like walls.

Dr. Lyman asked what amount of inflammatory action was going on. The reply was that there was no febrile movement at the time.

Dr. J. W. Elliot reported

A Case of Double Uterus and Vagina.

The patient was thirty-four years of age, had been married sixteen years, and complained of sterility, constant pain in the lower part of the abdomen, dysmenorrhœa, mental depression, and nervous spasms. On April second she entered Dr. Elliott's private hospital and was examined under ether. There were two separate vaginæ, both slightly smaller than usual; the septum, about one eighth of an inch thick, began just behind the hymen. At the end of each vagina was a cervix slightly smaller than normal. A probe could be passed into each cervix. The bimanual examination showed distinctly that there were two independent uteri; both were enlarged; one anteflexed, the other in about the normal position. The patient was afterwards seen during menstruation, and the menstrual flow came from both uteri.

Dr. Davenport asked if examination had been made by rectum.

Dr. Elliot replied that rectal examination gave the same result as by vagina; the finger passed behind both cervices and felt the double fundus above; without ether, however, nothing could be felt but the double cervix.

Dr. Chadwick expressed skepticism as to whether a double uterus could attain such a size as the reader had stated, since the double uterus was usually an arrested development and therefore smaller than the normally developed uterus.

Dr. Elliot said that the size of the double uterus was large in this case; he thought the bodies were dilated by fluid, there being stenosis at the ora interna. The menstrual flow is profuse.

Dr. Elliot also reported a case of

Retroversion of the Gravid Uterus.

He was called to Mrs. E. in Brookline, on March 9, found the family much alarmed, and the patient in a critical condition. She said she was 33 years old and had been married three months, and that the catamenia had not appeared for two months. Three weeks before he was called the patient began to vomit; for the first week she retained very little food, and for the last ten days she had retained absolutely nothing. She had been under the care of a homœpathic physician, who had not succeeded in relieving her. A female homœopathic gynecologist had relieved her

for one day by the use of the soft rubber ball pessary, but this caused flowing and was removed.

When Dr. Elliot saw her she was very thin and worn, and was tossing about the bed in a state of extreme nervous and physical exhaustion. She was retching and spitting incessantly, even when not attempting to take food. On examination he found the uterus somewhat enlarged, very low in the pelvis, and retroverted. She was flowing. There was evidently retroversion of a pregnant uterus, and a beginning miscarriage caused by pressure of the soft rubber ball pessary. He pushed the uterus up out of the pelvis and directed her to lie in the semi-prone position; this relieved her for a time, but in the afternoon of the same day she sent for him again and he found her vomiting as badly as before. He found the uterus had again partly retroverted, but the flowing had stopped. He put the patient in the knee-chest position, and replaced the uterus without difficulty. He then placed a pessary which held it in position, and the vomiting ceased almost immediately, and has never returned. The patient was able to take food every hour, and the second day she took two quarts of milk. She regained her strength very rapidly, and is now in prime condition. He removed the pessary in about two months, when the uterus had grown so large that it could not retrovert. Although the vomiting was relieved by replacing the uterus, the spitting continued to trouble her more or less for several months.

Dr. Fifield asked whether, when the patient was placed in the genu-pectoral position and the perineum was retracted with a Sims' speculum, the uterus replaced itself.

Dr. Elliot said that it was necessary to draw down the cervix with a tenaculum and push the fundus into place.

Dr. Chadwick asked the reporter if he ever saw the uterus replace itself with the patient in the genu-pectoral position.

Dr. Elliot said no, unless the blade of the speculum was long enough to push the fundus forward.

Dr. Chadwick thought the knee-chest position a poor one for replacing an uterus. If the cervix is hooked down, the uterus can be replaced, but he disbelieved in hooking down the cervix. He had raised the fundus by inflating the rectum, but he now places the patient in an erect position, when the uterus sinks, and, when the vagina is lax, can be easily replaced. He considered the erect position far better than the genu-pectoral.

Dr. Elliot saw no objection to the use of the tenaculum, and believed the knee-chest position a good one when it was desirable to use as little manipulation as possible.

CONCERNING THE ETIOLOGY AND PATHOLOGY OF HYDRAMNIOS.

Dr. C. M. Green read a short paper on this subject.

Since writing the paper which I read to this society in February last,

wherein I sought to formulate the present knowledge on the origin and pathology of hydramnios, I have met with another contribution to our knowledge of the subject by Dr. Nieberding, of Würzburg, who has recently observed and carefully recorded two cases. (1)

In the winter of 1883 Nieberding observed hydramnios in a case of twins from one ovum, which he reported in a monograph entitled Beitrag zur Kenntniss der Genese des Hydramnion. In this case not only was one twin more developed than the other, but there was considerable effusion in its cavities and great œdema of its whole body, hydramnion existed in only one of the amniotic sacs, and that one contained the larger fetus. The placenta was single, and that part of it which nourished the larger fœtus was of greater size, and was in a high degree infiltrated with serum. The pregnancy terminated at the end of the sixth month, and while the smaller fœtus showed no anomaly except a certain hyperæmia, examination of the larger fœtus disclosed considerable hypertrophy of the heart and kidneys, and great infiltration of all the organs with red and white blood corpuscles. The hypertrophy of the heart was chiefly of the left side.

If the question is asked, says Nieberding, to what causes are to be attributed the pathological increase of the liquor amnii of one sac and the dropsy of the fetus contained in this sac, it must be answered that an increased transudation from the maternal bloodvessels might have been the causal factor. Since, however, the size and presumably the permeability of both embryos were originally approximately the same, there is no reason why one sac should be thus filled and not the other. The idea that the vasa propria of one part of the placenta contribute conspicuously to increase the amount of the liquor amnii over and above the same vessels of the other part, Nieberding says must be abandoned, since it was established by microscopical examination in this case that the chorionic capillaries were equally developed on both parts of the placenta, and that those of the hydramnic part, instead of remaining patent longer than usual, were in a great part obliterated. Nieberding therefore believes that the cause of the hydramnic condition of one sac, in conjunction with the dropsy of the contained fetus, must be sought in the circulatory conditions of the fetus, and this belief is warranted by the pathological appearances in the present case, which were as follows:

Hypertrophy of the heart, especially of the left side; great enlargement of the kidneys, with dilation of the pelves, filling of the glomeruli with red and white blood corpuscles, and the presence of moderate blood extravasations; considerable dilatation of the ureters and of the bladder, although the urethra was entirely permeable. These pathological changes must have their causes, and these changes were traced by Nieberding to a

1 *Allgemeine Wiener Medizinische Zeitung*, March 11, 1884.

premature obliteration of the ductus arteriosus. The early closure of this duct must surely entail great changes in the fetal circulation, more blood must perforce enter the lungs, at the same time the blood tension in the right ventricle must be greatly increased. On account of this tension not only would there result a great backing up in the whole venous circulation, but at the same time a greater quantity of blood would be forced through the foramen ovale into the left side of the heart, which on account of the greater demands thus made upon it to force on the increased amount of blood, would hypertrophy, and thus increase the arterial tension. Herein, according to Nieberding, lies the explanation of all the anomalies of the affected ovisac and its contents, while the fetal œdema and dropsy were caused by the venous backing up, which, through the umbilical veins, occasioned also the serous infiltration of the placenta, the increased arterial pressure resulted in the increased infiltration of the kidneys, an increased diuresis, this increased amount of urine must have been evacuated from time to time, else there must have been an enormous distension of the bladder, and this polyuria, according to Nieberding's firm conviction, must have had the most conspicuous share in the dropsical distension of one ovisac, while, on the contrary, the weakened heart of the other twin caused a lowered arterial tension, a smaller secretion of urine, and a minimum amount of fluid in its containing amnion.

Quite recently Nieberding had a second instance of hydramnios in a case of single fœtation. A previously healthy secundipara, thirty-two years of age, whose first pregnancy and labor had pursued a normal course, and who was in the sixth month of her second pregnancy, sought advice on account of uterine hemorrhage. Examination showed that for the time of pregnancy the abdomen was much distended, and that the position of the fundus uteri corresponded to that of the end of pregnancy. The fetus was living, but was very small, and was very freely moveable in the great amount of liquor amni. The hemorrhage ceased under the influence of rest and opiates. Two weeks later Nieberding found that the circumference of the abdomen had increased to such an extent that the woman was greatly distressed and had lost much strength. At the same time there was marked œdema of the legs and also of the vulva, indeed, each of the labia majora had swollen to the size of a man's two fists. The fetal heart could no longer be heard. On account of these symptoms Nieberding induced labor on the following day by puncturing the membranes; an enormous quantity of liquor amnii escaped, sufficient to fill one and a half times a large water pitcher.

The fetus, female, twenty-four hours dead before delivery, was well developed, and corresponded to the beginning of the seventh month of pregnancy. On opening the abdomen the bladder showed itself greatly distended with urine and extended as high as the navel; the urethra was completely passable with a small catheter. The heart was very large,

and was hypertrophied in its left half, it was larger than the heart of the pathological twin in the first case, the muscle was healthy and the valves normal. In the lungs, as in the first case, was observed, besides a considerable blood cell infiltration, a large increase in the calibre of the arteries, with a well-marked thickening of the vessel walls. The liver was large and infiltrated with red and white corpuscles in the vicinity of the vessels. The kidneys were enlarged, and there was dilatation of the pelves and calices, the glomeruli were filled with blood cells, and there was blood cell infiltration of the parenchyma. The placenta was large and very œdematous, and studded with a great number of cysts, from the size of a hazel nut to that of a hen's egg, which were seated more or less in the vicinity of the chorionic covering of the placenta. The cord was inserted near the edge. Countless old and new blood clots, some of considerable size, were found as well directly under the chorion as upon the uterine surface of the cotyledons. Under the microscope was observed, as in the first case, frequent obliteration of the vessels, with greatly hypertrophied vessel walls, which gave the impression of fibroid growths, which were perforated sometimes by one, but commonly by two very small vessel openings. The cysts hung, as it were, on the vessels which were in intimate connection with the cyst wall. Section of these vessels at their seat of passage into the cyst showed that an artery and a vein lay together, the artery appeared obliterated before its insertion into the cyst wall, in order to develop itself as a cyst. The vein, much dilated and drawn out surrounded the obliterated artery in a half-circle, so as to lie smoothly over the cyst wall. In the cyst fluid were found countless more or less altered red and white blood corpuscles. Finally, the vasa propria of Jungbluth were seen traversing the chorion, not in great number, but often beautifully injected.

On laying open the ductus arteriosus lengthwise, Nieberding found its lumen filled with crumbling masses which reduced considerably the calibre of the duct. Microscopic examination showed these masses to be proliferations of the muscular coat and intima, as in the first case. He, therefore, has no hesitation in considering the premature obliteration of the artertal duct the primary anomaly on which the circulatory disturbances of the fetus and other pathological changes depend. He also believes that the great amount of liquor amnii arose from the extraordinary increase of urine secretion, without, however, entirely denying that other factors may have had some share in the increase. Nieberding adds that it now remains for him to examine the arterial duct of fetuses of the same period of pregnancy where hydramnios does not exist, in order to prove whether perhaps the physiological obliteration of the duct can occur at full term without being accompanied by so considerable anomalies of the ovum.

It does not seem to the writer that Nieberding's cases and conclusions,

however interesting they may be, change materially the already accepted views on the pathalogy of hydramnios. Any pathological change in the fetus, in the cord or placenta, which so disturbs the circulation as to cause venous stasis or increased arterial tension, would naturally result in dropsical effusion or increased filtration of urine; the fetal skin and kidneys, and perhaps the umbilical cord and chorionic vasa propria, would thus naturally contribute to increase the amount of liquor amnii. Wherever the disturbing cause is found, the final result is always found to be the same.

DISCUSSION.

Dr. Benj. Cushing, present by invitation, alluded to the methods now advocated for the removal of the placenta after abortion. He formerly used ether, and introduced his hand or a placental forceps, but for the last twenty years had used an instrument of his own devising, a small scoop or spoon with a long handle. It was far better than the placental forceps.

Dr. Chadwick had used the scoop for the last four or five years, and thought it of as much value as Thomas' serrated scoop. — *Boston Medical and Surgical Journal.*

NEW YORK OBSTETRICAL SOCIETY.

Stated Meeting May 6, 1884.

President, W. M. Polk, M.D., in the Chair.

Papilloma of the Vagina.

Dr. W. M. Chamberlain presented a specimen, removed from the vagina of a woman about fifty-five years of age. He had seen the patient in consultation, and the attending physician had given the following account of the case, as observed through a period of several months:

"The patient was conscious of the presence of a tumor which impeded urination and yielded a watery and bloody discharge at intervals. A surgeon of some repute had seen her and pronounced the case to be one of carcinoma extending downward from the uterus and involving the posterior as well as the anterior vaginal wall to such an extent as to preclude all question of removal, and had advised that treatment should be limited to securing tolerable comfort to the patient, the suppression of hemorrhage, disinfection, and the use of morphine as an anodyne."

A considerable hemorrhage had occurred the day before Dr. Chamberlain was called to see her, and a mass of spongy tissue had protruded. The woman was extremely exsanguinated and hectic.

The vulva was occupied by a mass of large vegetations, and the vagina so crowded with the same that the finger was with difficulty carried through the center of the mass up to the uterus, which could not be made out as much enlarged or very firmly fixed. Examination was

followed by such bleeding as to require a tampon, and to inspire a doubt as to whether any more radical procedure could be employed. On the following day, however, the tampon was removed, and the protruding part drawn down was seen to have a broad base of attachment to the superior wall of the vagina. This base was constricted by a strong elastic ligature, and a mass as large as a medium-sized lemon was cut off with the scissors. A large amount of tissue was quickly scraped away with the finger-nails, and a tampon of glycerole of alum was rapidly inserted. After a few days the operation was repeated with the large sharp curette, and a saturated solution of chloride of zinc upon cotton was applied to the base. Thus the vagina was gradually freed until a speculum could be used. The os uteri was found small, and, though it was more or less covered with vegetations, the disease seemed to be limited to the surface. The anterior vaginal fornix still contained some of the growth, but the patient was so much improved and relieved that she was able to go to her home, out of town. Defecation and urination, which had been very difficult and painful, had become natural, and the discharge was almost suppressed.

The tumor had been carefully examined by Dr. F. Ferguson, who had made the following report:

"The tumor is composed of a fibrous stroma with abundant smooth muscle-cells, supporting epithelial cells distinctly nucleated and of large size. The arrangement of the stroma is not such as to classify the tumor readily, but it is closely allied to the variety of epithelial tumors called "*papilloma*". From the enormous size of the papillæ of which the tumor is composed, and the bountiful supply of epithelial cells, which are in a state of active proliferation, the prognosis is rather unfavorable. If the tumor be completely removed, its tendency to return will not be so marked as that of carcinoma or sarcoma."

Meeting of May 20, 1884.

The President, W. M. Polk, M.D., in the Chair.

Rupture of an Ovarian Cyst with Colloid Contents.

Dr. P. F. Mundé presented a specimen, and gave the following history: About two months ago a patient entered his ward at Mt. Sinai Hospital with evidence of an abdominal enlargement which she first noticed last August, at which time she fell upon the right side of the abdomen and experienced sharp pain. The abdominal enlargement was diffuse, and had been steadily increasing since the accident. Her general health, although fair, was not so good as it had been. Dr. Mundé was able by a superficial examination to determine that the abdominal enlargement was not due to fluid contained within well-defined cyst-walls, and was inclined to the opinion that there had been rupture of an ovarian cyst. The patient was afterward put under chloroform, and a

very thorough examination was made in the presence of a number of gentlemen. The abdominal wall projected on either side; there was fluctuation with dulness, not changed by altering the position of the patient. It was decided to perform aspiration, but nothing was withdrawn. No bad results followed this procedure. A diagnosis was now made of rupture of a multilocular cyst with colloid contents, which had produced general chronic peritonitis and deterioration of the patient's health. In addition there was on the left side a tumor, of the size of a cocoanut, which was immovable and gave indistinct fluctuation. This was supposed to be an intra-ligamentous cyst of the left ovary. Although the diagnosis was uncertain, the patient was told that the sooner an exploratory incision was made the better. After a few days' consideration she decided, inasmuch as her health was fairly good, not to have anything done. Three weeks later she returned, suffering from a great deal more pain, and in much worse general condition. The temperature had been normal, but was now 103° F. It sank, however, under large doses of quinine. On opening the peritoneal cavity, very thick colloid material was encountered, which came away in strings. The patient was turned on the side, and as much of the colloid material as possible was washed out by irrigation with corrosive-sublimate solution, 1 to 2,000. The pedicle of the ruptured cyst was tied and dropped in the usual way. All of the peritoneum below the umbilicus was intensely inflamed, being of a purple-red color; it was thickened and covered by an exudation, particularly on the right side. Above the umbilicus the color was normal, although there was no apparent reason why the inflammation had not extended to that region. The tumor on the left side was found to be an intraligamentous cyst which he was in doubt about how to treat. At the suggestion of Dr. Polk he tried enucleation, which was easily accomplished, but the cyst was so fragile that on slight manipulation it ruptured. Its contents were highly fetid pus. This accident, however, had nothing to do with the death of the patient, which took place from shock about twenty-two hours after the operation. It was thought likely that the patient would have recovered had she submitted to an operation when it was first advised. The case was interesting from a diagnostic point of view, from the fact that the patient had gone as long as nine months since the rupture of the cyst had taken place, and, further, from the peculiar ropy character of the material in the peritoneal cavity. The colloid matter found in the peritoneal cavity weighed thirteen pounds.

Supra-Vaginal Amputation of the Uterus for Uterine Fibroid.

Dr. Mundé related a second case and presented the specimen. Last autumn a physician from Harlem brought a patient to his office who was found to be suffering from a subperitoneal uterine fibroid. The

uterus was of about its size at the sixth month of pregnancy. The chief symptom was abdominal pain. Menorrhagia was not very severe. Dr. Mundé advised against operative interference; ergot was given to control hemorrhage, and for a time was effectual. In April a letter was received, stating that the patient suffered so much from pain that she was obliged to resort to morphine, and desired an operation. Examination showed little change in the size of the tumor; it reached to the umbilicus, and was movable and fairly hard. There seemed to be no special demand for the operation excepting severe pain. Last Friday an incision was made, reaching from the umbilicus to the symphysis pubis. The tumor was non-adherent, and was lifted out without any difficulty. The left broad ligament was tied in two places, and the ovary and tube were tied off. The right ovary was adherent too low down to admit of this treatment, and he was obliged to ligate above it, leaving the ovary and tube to be removed subsequently. This was done by ligatures, and the tube, which could not be included in the ligatures, was seared with Paquelin's cautery. It was intended to apply an elastic ligature around the pedicle and leave it in the abdominal cavity, but the only one at hand proved to be rotten and worthless. The pedicle was then transfixed in an oblique direction by two long pins, and an ovariotomy clamp was applied beneath. A hysterectomy clamp could not be obtained. The clamp used failed to make sufficient compression. He then applied the Maisonneuve *constricteur* beneath the clamp. It had to be applied so far down that it was impossible afterward to sew the peritoneum at all points of the circle below the wire. When the uterus was removed most of the upper part was found to be involved in the tumor. The pedicle was secured in the lower angle of the abdominal wound. On loosening the *constricteur*, with intent to remove it, blood spurted, although the large arteries in the stump were separately ligated, and it was again tightened and allowed to remain. The stump was cauterized with a saturated solution of chloride of zinc, and the wound was dusted with iodoform. No drainage-tube was used. The patient rallied well. The temperature on one occasion went up to 102° F., when the ice-coil was put on, and it came down and had not again risen above 100°. There had not been a single bad symptom during convalescence. The pedicle was now ready to fall off. There had been considerable suppuration after the fifth day, but none of the fluid entered the peritoneal cavity.

Labor at the Sixth Month complicated by a Large Cervical Fibroid.

Dr. Mundé also narrated the third case, that of a patient who came to the hospital two weeks ago, with a history of bleeding during her last labor, due to placenta prævia. Examination revealed two tumors, a soft one extending from five inches above the pubes to the diaphragm, and a

harder one extending down into the pelvis. The lower tumor could be felt through the vagina. The patient said she could not be pregnant, for she had been bleeding for several months. She was very much exsanguinated. Dr. Mundé diagnosticated, in addition to the tumor, pregnancy of about the sixth month. The tumor was apparently connected with the anterior cervical wall, and filled the pelvic cavity. One of two courses might be pursued: First, to wait until term and perform the Cæsarean operation; or, second, to enucleate the tumor through the vagina, which might be done at once or at term. He thought it would not be so favorable for the patient to wait until term, because the tumor in the meantime might become considerably larger. Hence he decided to enucleate the tumor by the vagina, and fixed the day for the operation. On the morning of the appointed day the patient began to lose blood and to suffer pain, and, when he reached her, he found labor had come on, the cord and a hand protruding through the cervix. Pain was quieted by morphine, and a few hours later he proceeded to remove the tumor by enucleation with the fingers and Thomas' serrated spoon, having first made an incision five or six inches long into the capsule. No difficulty was experienced in enucleating the growth until the upper attachments were reached. It was found to weigh three pounds, and to measure eight inches in length by twenty inches and a half in circumference. A fetus of about the sixth month was then extracted without any trouble. The patient lost comparatively little blood, but the shock was quite severe. She rallied well, however, under hypodermics of whisky. The cavity of the tumor was stuffed with iodoformed gauze, which was removed on the second day. The temperature on that day went up to 102° F., but fell under the ice-coil and quinine, and to-day was normal. The patient was doing well, and doubtless would go on to perfect recovery. He had been able to find but one case on record, that of Prof. Schröder, in which the patient was permitted to go on to term. In that case the tumor was then removed by vaginal enucleation, and both child and mother survived.

Dr. W. T. Lusk said he was rather surprised when he witnessed the operation, in the first case related by Dr. Mundé, to observe that the ovaries and tubes were not carried up with the tumor as in a case of pregnancy.

Dr. J. B. Hunter thought the explanation probably lay in the fact that the ovaries and tubes had become bound down below the uterine fibroid. He referred to a case in which he removed the uterus at the cervix, and hemorrhage was controlled perfectly by the elastic ligature.

Dr. Polk, the President, remarked that the question how to get the peritoneum in contact with the stump below the ligature when there was great tension was an important one, and asked the gentlemen if any of them could give suggestions on that point.

Dr. Hunter suggested transfixion with a strong silk ligature, and then tying the stump and dropping it.

Dr. Mundé had seen two cases in which the pedicle was tied and dropped, and the patients died.

Dr. Hunter remarked that his patients so treated had recovered. In one the cervix sloughed away after the operation.

The President remarked that in a case in which he had performed hysterectomy the cervix also sloughed away, although the patient made a good recovery.

Dr. Mundé replied to a question by Dr. Hanks, with regard to the third case, that the fibroid had probably been one of the fundus which had worked its way down to the cervix.

Dr. Lusk called attention to the fact that about two years ago Dr. Kessler, by invitation, presented a specimen to the Society removed from a patient in whose case the result of the operation was different. Premature labor took place at about the seventh month, and, it being impossible to remove the placenta, she died of septicemia. The tumor filled the entire lower uterine segment. In the light of the case reported this evening by Dr. Mundé, it would have been well had an attempt been made to remove the tumor in the same manner. Dr. Lusk had requested Dr. Kessler to present the specimen for the purpose of drawing out an opinion as to the propriety of attempting enucleation, and Dr. Thomas and others then thought it would have been folly to attempt it. He mentioned this as an illustration of the rapid strides that had been made in uterine and abdominal surgery.

Dr. H. T. Hanks said he reported a case to the Society seven or eight years ago, in which Dr. Thomas saw the patient and performed the Cæsarean operation. The tumor was much smaller than the one presented by Dr. Mundé, but it was within the cervix and prevented the birth of the child in the natural way. He believed that, at the meeting Dr. Lusk referred to, he asked Dr. Thomas whether, since he had devised his spoon-saw, he would not enucleate the tumor in such a case, instead of performing the Cæsarean operation, and he replied he certainly would.

Dr Mundé added that enucleation was much easier to perform in this case than it would have been in a non-pregnant woman.

Dr. Hanks reported, with regard to the case of puncture of the gravid uterus in the performance of ovariotomy, followed by miscarriage after the patient's convalescence and discharge from the hospital, that he had lately delivered the patient of a well-developed child at term.—*New York Medical Journal.*

THE OBSTETRIC GAZETTE and LANCET AND CLINIC to one address, one year, for $5.

Correspondence.

IS IT NECESSARY TO PERMIT WOMEN TO SUFFER DURING THE FIRST STAGES OF LABOR?

Editor Obstetric Gazette:

In your September number I find a paper by Dr. I. W. Chisholm under the above heading. He shows by his action that he replies properly in the negative. Not only is it unnecessary, but I regard it as being highly reprehensible to allow any woman to suffer, especially as is so often the case, when from some vice in the system she will commence hours, even days, prior to delivery with pains which are utterly useless and greatly exhausting. In the early years of my practice I employed morphia, but now, since 1869, I invariably give chloral, and I have never failed to see the happiest results. When called to a case and I find the woman suffering with pain at intervals, little or no dilatation of the os uteri, I immediately administer a positive dose of chloral, from ten to twenty grains, with orders to repeat in an hour or two if required. I tell my patient that this will not delay the labor, but merely act as a partial anæsthetic to relieve her sufferings. It is always best to so instruct the patient and her attendants, as otherwise I have returned to find them endeavoring to keep the patient awake in order that she may go on with her labor. Make a full explanation of the true condition of affairs and of the expected results to be obtained from the medicine. When these are false pains they are speedily dissipated, the woman has a refreshing sleep, and may go on for a number of days in much comfort until true labor sets in. Or she awakes refreshed, invigorated, and, in many instances, on my return, I have found the os uteri fully dilated and the labor rapidly progressing to a favorable termination. Where the physician believes the labor to have really commenced, after giving such treatment, he should always return after the expiration of a few hours, as otherwise he may be regarded as neglectful should the labor under the influence of the chloral be terminated in his absence.

I will refer your readers to my views on this point in my "Hints in the Obstetric Procedure," and also a paper published, I think in 1875, in the *Medical and Surgical Reporter* entitled "Chloral." Yours,

Philadelphia, Oct. 28, 1884. WM. B. ATKINSON, M.D.

THE FEMALE URETHRA.

Editor Obstetric Gazette:

In the October number of your valuable journal I noticed an article (from the *British Medical Journal*) on the female urethra, in which there is some confusion of authors and subjects. Several statements made

might be questioned, but I will only notice the following: "Recently Dr. Max Schuler, of Berlin, has published the results of a series of dissections, and his conclusions tend to subvert the theories of Skene and the morphologists, the ducts appearing to be the outlets of a distinct pair of glands." What effect Dr. Max Schuler's dissections may have upon the theories of the morphologists I know not, but I do know that they cannot subvert any theories of mine, simply because I have never formulated any theories regarding the glands of the female urethra.

Several years ago I gave (in the *American Journal of Obstetrics*) a description of the anatomy of a pair of glands and their ducts located in the walls of the female urethra, and also described the pathology and treatment of several diseases which effect these structures, and all that has been said by our professional friends in Europe since then appears to be a repetition of the facts which I then brought before the profession. The description of the anatomy of these glands and their ducts, as given by Schuler, differs in no essential from that which I had previously given. In place of subverting any thing of mine Schuler confirms the anatomical facts originally expressed by me.

I hope, Mr. Editor, that you will aid in drawing the line of demarcation between the progress of science in Europe and America by giving my note a place in your journal. ALEX. J. C. SKENE, M.D.

ERRATA.

The October number of your journal is at hand and I notice the following typographical errors in the article on "Diversity, or Modified Heredity": page 511, fifth line from bottom, *forms* should be *from*; two similar errors in the line below; on page 515, thirteen lines from the bottom, *futile* should be *fertile*. Respectfully, D. H. JAMES, M.D.

Aurora, Ind., Oct. 28, 1884.

WHAT IS THE BEST TREATMENT FOR CONSUMPTION? — Having used MCARTHUR'S SYRUP OF HYPOPHOSPHITES for more than a year, I would like to report to you one case in particular. In June last I was called to see a young man, age 18, whose mother and one brother had died from phthisis. I found him suffering from severe pleuritic pain, night-sweats, severe distressing cough, and profuse expectoration, characteristic of first stages in phthisis, tongue coated, pulse 128 to 130, temperature 104° at night, profuse crepitus in lower half of left lung, dulness on percussion over almost entire left side, intercostal depressions marked in left mammary, extending backwards into left axillary region, no appetite, and general facial expressions of rapid emaciation, etc. I began the use of McArthur's Hypo. Comp., and continued it four months, using some other means for night-sweats and such other conditions, as seemed to require attention. To-day the young man is about the farm doing light work; appetite excellent, no cough, no night-sweats; the wasting of the lung substance is arrested, leaving dulness in lower left lung, vesical murmur gone, but the disease is temporarily arrested at least, and he has increased his weight forty-three pounds. With care I expect to get him through the winter in good shape, and possibly a permanent recovery may ensue. I have used the Syrup in five other cases during 1883 with gratifying results. CHAS. F. BRANCH, M.D.,
Secretary Board U. S. Examining Surgeons,
Coventry, Vt. Office of Board, Newport, Vt.

Abstracts and Selections.

I. — OBSTETRIC.

Cesarean Section—Recovery.—By J. A. Shrader, Monroe, Ia.

I was called to see Mrs. Mary A. Sinclair July 21st, 1882, who presented the following history:

Æt. 31 years, married four years, temperament nervous; primipara. Had hip joint disease at eight years of age, and since then there has been a tumor growing from right pelvic wall. Right leg shortened seven inches; cannot separate her knees more than four inches. She commenced to menstruate at 17, but was never regular until after her marriage. Discharge from hip ceased after she commenced to menstruate. Abdomen greatly enlarged and very painful when touched, so much so, indeed that she would scarcely allow me to touch her at all; and as to an examination *per vaginam*, she would not hear of it. Menstruation was hardly normal in January, February and March. She missed April and May, She claims that she had a colored discharge in June. She first noticed a tumor in right lumbar region in March, and says that when abdominal tenderness was less, she could "push it clear across her body." The tumor was attached to the right pelvic wall, filling the pelvic cavity (which I knew nothing of at this time) and extended about two inches above the crest of the ilium. The abdomen had been quite tender since March. As I could make no further examination, I prescribed iodide of potash in large doses internally, and tr. iodine to be applied freely over both pelvic growth and abdominal tumor. She denied having ever felt life or any movement whatever in abdominal cavity. The stethoscope failed to reveal fetal heart sounds. The mammæ indicated pregnancy; but that must not in such a case be taken as a positive sign. But there was something about the general appearance of the case which inclined me to think her pregnant. Yet, when I expressed this opinion, she got very angry—would not hear of it.

She has since told me, and her husband corroborates her story, that she had hard labor pains from June 29th to July 5th. Labor came on again July 25th and lasted until the 27th. This was kept from me for some reason—why, I cannot say.

I was called to see her again August 1st. The tenderness had almost entirely gone from the abdomen, and after a careful examination I told her that she was pregnant. Fetal movements could be distinctly felt. She still denied feeling the movements. I could now feel the tumor that she said she "could push clear across her body," and diagnosed it a subperitoneal fibroid, which afterward was found to be correct. She still would not submit to an examination *per vaginam*.

On August 12th I was sent for again. I found her in labor which lasted for forty-eight hours. After sixteen hours her pains were weak and irregular; but for several hours after my arrival, her pains were regular and of great expulsive force. On examination I found the os apparently healthy, but not dilated at all. It was drawn to the left, and, from her crippled condition, was almost out of reach. In fact, I could not bring it within reach at all, except by making her lie on her left side with her limbs well flexed. Could feel what I supposed was the fetal head from its shape and solidity—it was fully as hard as the fetal head should be. After remaining with her for fourteen hours—the pains becoming irregular and weak—I left her in the same condition I found her, i.e., labor had made no progress whatever.

I came to the conclusion that I had a bad case to deal with, and, as I was not fully convinced that the round object felt within the pelvis was a fetal head, would prepare the husband for whatever might be necessary, and explained to him the operations sometimes rendered necessary from deformed pelvis, growths from the pelvic wall, uterine tumors, etc.

I was called again August 27th, and found her as at my last visit—os not dilated the least bit. Abdomen had enlarged rapidly since my first visit in July. Pains were regular and strong. I staid over night with her, and as the pains seemed to be dying away, took my leave—wishing that some one else had the case. Her health had been good since the pain and soreness left her abdomen in July. I was sent for again September 10th, but not being at home, did not see her until the 11th. I found her with fair labor pains. Had then been in labor thirty hours. An examination revealed nothing new. Made speculum examination. Os healthy, cervix not shortened, passed sound carefully into uterus to a depth of five and a half inches before meeting with any obstruction. The cervix seemed to be two or three inches in length. I staid with her until midnight, and as the pains were becoming less frequent, irregular and weak, I left. Visited her twice on the 12th. No change in her condition, except her pains were stronger. I resolved to dilate the cervix, and for this purpose introduced a small sponge tent. Removed it after twelve hours, and as I could not pass a finger introduced two tents, which I left in place until the 13th, when, upon their removal, I found the os dilated sufficiently to admit a finger probably half the length of the cervix only.

Sent for Dr. N. R. Cornell, of Knoxville, as counsel. Upon his arrival, we succeeded, after three hours labor with Barnes' dilators, in dilating sufficiently to pass a finger; but could feel nothing within the uterus. It revealed the fact that what appeared to be a fetal head was the tumor springing from the pelvic wall, and that there was not a pelvic diameter of more than three-fourths of an inch. A rectal examination revealed nothing which would render an accurate diagnosis possible.

As craniotomy and all other operations for the removal of the child

were out of the question, except Cesarean section, we explained the operation to husband and wife, with the possible chance of recovery, and left it with them to say whether they would have the operation performed or not. They deciding in the affirmative, we concluded to defer the operation until morning, as it was then midnight. Her pains ceased when told that an operation would have to be performed, and did not return. Ordered that a tablespoonful of alcohol well diluted be given her every hour from 3 o'clock a.m., until our arrival. She had suffered but little, seemingly, from the great length of time she had been in labor (four days) and we found her in good spirits and feeling well.

We administered Squibbs' ether at 10 a.m. of the 14th, and after some difficulty got her under its influence. The operation consisted in making an incision five and one-half inches long, commencing one and one-half inches above the umbilicus and directly through the linea alba. But two arteries were found that needed attention. The uterus presented a rather singular appearance. On the right anterior wall were found a sub-peritoneal fibroid tumor as large as a man's fist—well pedunculated, while from the left posterior wall sprang another growth of the same kind nearly as large. Running diagonally across the organ from left to right were four cords—the two larger being about one-half inch in diameter, and so hard that it was with difficulty they were cut through. They were imbedded in the uterine tissues to about one-half their diameter. The uterine incision was made of the same length as the abdominal, the wall of which at the superior point of incision was two inches thick, gradually becoming thinner until at inferior point it was but one inch and a half thick.

The uterine tissues were so firm the whole length of the incision that it could hardly be cut through. After rupturing the membrane, the child was grasped and removed alive. Considerable hemorrhage followed the removal of the placenta, but after thoroughly swabbing out the uterus with ferri sub-sulph. and giving sub-cutaneously one-half dram liquor ergotæ, the organ contracted and hemorrhage ceased. After the removal of all clots of any size, the edges were brought firmly together with silk sutures, cut close and left, as it was found impossible to carry the end of an interrupted suture through the cervix. The walls of the uterus were brought into such complete juxtaposition with the abdominal parietes by the fingers being hooked into either end of the uterine incision that but little blood or amniotic fluid escaped into the peritoneal cavity. But what little there was was carefully sponged out and abdominal incision closed by silk sutures. No drainage tube was used at any time. Carbolized glycerine was used as a dressing, and a good flannel bandage applied.

The operation commenced one hour from the time she commenced to inhale the anæsthetic. She was kept well under the influence of ether

during the whole time. She rallied well, and when I took my leave, at 1 p.m., both mother and child seemed to be doing well. The child weighed about five pounds. I hardly think it was carried to full time by three or four weeks.

Sept. 14th, 8:20 p.m., (First visit after operation) Temperature 100¼°, pulse 92, rational and feeling well. Says she will recover. I drew a pint of urine. Prescribed,

℞ Fl. ext. aconiti - - - - - - - gtt. xx.
Tr. cannabis indicæ - - - - - - gtt. x.
Ammoniæ mur. - - - - - - - ℈ j.
Aquæ - - - - - - - - ℥ v.

M. Sig. Take a teaspoonful every hour and a half. Also,

℞ Morphiæ sulph - - - - - - - grs. ⅛.
Bismuth subnit. - - - - - - grs. iij.

M. Sig. To be taken every three hours.

Child lived but four hours.

Sept. 15th, 10 a.m.; T. 99¾°; P. 104.

Sept. 15th, 6:30 p.m.; T. 102¼°; P. 108; treatment the same; has no pain; urine looks natural; tongue clean; has some appetite.

Sept. 16th, 9:35 a.m., T. 100½°; P. 100; lochia natural; abdomen not swollen.

Sept. 16th, 7:15 p.m.; T. 100¾°; P. 110; received a severe fright and abdomen swelled badly in ten minutes; continue treatment.

Sept. 17th, 5:10 a.m.; T. 100¼°; P. 116; abdomen swollen; not very tender; dressed incision; edges apparently uniting by first intention; removed lower suture; urine looking well; have it drawn every six hours.

Sept. 17th, 2:10 p.m.; T. 99°; P. 116; abdomen badly swollen and very tender; lochia natural; bowels not yet moved; use enemas of warm water every few hours.

Sept. 17th, 7:40 p.m.; T. 99½°; P. 110; some headache; bowels moved well; tongue covered with white coating; continue febrifuge mixture except the cannabis; ordered quiniæ sulph. grs. ii with each powder.

Sept. 18th, 10:20 a.m.; T. 99¾°; P. 92; passed urine naturally; incision looking well.

Sept. 18th, 8:20 p.m.; T. 101°; P. 98.

Sept. 19th, 10:40 a.m.; T. 99¾°; P. 104; tongue cleaning; bowels in good condition; appetite good; abdominal swelling subsiding; removed all the sutures, and support abdomen with broad bands of adhesive plaster.

Sept. 20th, 9:10 a.m.; T. 98½°; P. 88; lochia natural; treatment the same; extend interval between doses to six hours.

Sept. 21st, 9:10 a.m.; T. 101¾°; P. 114; discharge of pus from uterus; wash out uterus twice a day with carbolized water; not much abdominal enlargement or tenderness.

Sept. 22d, 8:35 a.m.; T. normal; P. 88; appetite good; tongue clean.

Sept. 23d, 6 a.m.; T. 97¼°; P. 90; had a bad night.

Sept. 23d, 5:10 p.m.; T. 101¾°; P. 98; is feeling better.

Sept. 24th, 2:30 p.m.; T. 98¾°; P. 98; bowels and kidneys in normal condition.

Sept. 25th, 1:20 p.m.; T. normal; P. 90.

Sept. 26th, 9:20 a.m.; T. 98°; P. 84; discharge of healthy pus from umbilicus and from near inferior point of section; discharge from uterus, muco-purulent.

Sept. 27th, 10:20 a.m.; T. 98⅜°; P. 86.

Sept. 28th, 9:45 a.m.; T. 98½°; P. 84. Two bedsores have made their appearance; ordered bal. Peru to be applied twice a day; parts to be cleansed with castile soap suds.

Sept. 29th; T. 98°: P. 74. Patient continued to improve steadily, and was discharged cured October 15th, one month and a day from the operation. The bedsores were entirely healed by the 10th.

There was no discharge from the uterus after October 1st. There was still a slight discharge from the umbilicus when I ceased my visits, but this subsequently stopped.

Dec. 22d. Saw Mrs. S. to-day for the first time in several weeks. Found her at work. Says her health is good. Has gained considerable flesh. Menstruation regular, but more profuse than before operation. Found a good deal of tenderness over right lumbar region. Tumor remained about the same in size. Milk was secreted first, about three weeks after the operation, and has continued quite profuse ever since. Uterus still greatly enlarged, reaching to umbilicus. The sutures used in the womb all came out through the umbilicus, this having remained open until the last one had been removed, when it immediately closed.

I visited her in March, 1883, she thinking that she was pregnant again. Introduced a sound and found the organ, six inches in depth and empty.

I saw her in May, 1883. She would still have it that she was pregnant—claimed that she could feel movements distinctly. To satisfy her, I again made an examination and found nothing within the organ; but the depth was then six inches and a half, and then reached two inches above the umbilicus. The sub-peritoneal fibroid of the right wall had entirely disappeared, probably absorbed. As to the posterior tumor, I have no way of knowing what has become of it, as it is not within reach of any external manipulation. I have not seen her for nearly a year, but her husband tells me that her womb is still enlarging slowly. Her health is good. Menstruation is still regular.

I think the whole organ might be classed as a tumor, but of what kind?—*St. Louis Courier of Medicine.*

Abortions, and Elixirs containing Strychnine.—Dr. George Pringle, in a communication to the Canada *Lancet*, points out a new danger from the use of the favorite elixirs containing strychnine. In three cases out of four, in which pregnancy was not suspected, the use of strychnine with a chalybeate brought on an abortion, and the fourth had symptoms of abortion which passed away on stopping the treatment, and again returned upon resuming it, so that the remedy had to be abandoned, and a tonic without the strychnine substituted. He advises that strychnine should not be given after conception has taken place, and that manufacturers should omit both strychnine and arsenic from elixirs sold to supply popular demand.

II.—GYNECIC.

Curetting the Uterus.—Düvelius (*Zeitschrift f. Geb. u. Gyn.*, x., 1) remarks upon the frequency of the operation of curetting the uterine mucous membrane within the past few years, though its propriety is still questioned by many. Whether it is performed for diagnostic or for therapeutic purposes, its opponents challenge: 1. The possibility of making a diagnosis of the disease of the mucous membrane from the material which is scraped away; 2. The possibility of curing a diseased mucous membrane by the use of the curette; 3. The possibility of a subsequent normal pregnancy. In the author's investigation of this subject he appears to have been able to obtain abundance of material, both from the living and from the dead, and this fact is worthy of notice. The uteri which were operated upon belonged to women between the ages of twenty and forty, excepting in three instances, in which they had passed their fiftieth year. The post-mortem specimens were removed within twenty-four hours after death, and had neither suffered post-mortem changes nor been affected with disease, so far as could be ascertained. The operation was performed upon these specimens in the same way in which it is customarily performed upon the living subject; the specimens were hardened in absolute alcohol, and sections were then made in all directions with a microtome. Microscopical examination showed that in some cases the mucous membrane had been entirely removed, quite to the muscular structure of the uterus, while in others more or less had been left behind. In most of the sections, either deep in the muscular structure or else superficially, the remnants of larger or smaller glandular tubes were seen, which had been torn obliquely. Nowhere was mucous membrane found with its superficial epithelium intact; and, since disease of the uterine mucous membrane could hardly exist without involvement of its superficial epithelium, the first objection of the opponents of the operation is answered by reason of the abundance of the products which may be removed with the curette. In five cases of disease of the uterus the author was able to correctly diagnosticate the disease by means of

small portions of mucous membrane which were removed with the curette. In two of the cases the microscopic examination of the products of the curetting indicated carcinoma of the body, in two malignant adenoma, and in one sarcoma of the mucous membrane. The uterus was removed in all the cases (from the living subjects), and the diagnosis confirmed. In regard to the second objection, two questions become pertinent—(1) whether after curetting of the uterine mucous membrane a renewal of that membrane is possible; (2) whether the new growth, if any, holds the same relations to the muscular tissue of the uterus as in the normal state, and whether or not scar-tissue is formed. Bearing upon this subject, two patients came under the author's notice who were subjected to repeated curettings with subsequent caustic applications to the denuded surface. The object of the operations was to overcome a tendency to profuse hemorrhages, and, after they had proved ineffectual, the uteri were amputated. Microscopical examination of the specimens showed the presence of the same histological elements which exist in the normal uterine mucous membrane, but they were abnormally arranged. A cicatrix was not found either in the mucous membrane or on the border between it and the muscular tissue. This result was also confirmatory of the investigations and results of Leopold in the same field. The third objection is groundless not only from observed facts, but also because it has already been shown that no cicatrization of the mucous membrane takes place, and that that membrane is not brought into an abnormal condition by the operation in question. The effect of curetting and the subsequent application of stimulating substances to the surface operated upon is to remove the accumulated secretions, and to remove the superficial or even the deeper layers of the epithelium, and no evidence has been brought forward to show that its influence is destructive of function; on the contrary, the author's experience has been that its effect is highly beneficial. Sixty cases of pregnancy were observed in the years 1879 to 1883, in which the women had undergone curetting previous to conception. In some of the cases it was even ascertained that a tendency to abort had been cured by the operation, and the women were enabled to carry their fetuses to term.—*N. Y. Medical Journal.*

Uterine Displacements and their Treatment by Means of Medicated Tampons.—Dr. R. Bell's paper (*Edinburgh Medical Journal*, March, '84) was read before the Edinburgh Obstetrical Society, and offers objections to the too frequent use of the pessary. The views of the author, like those of other gynecologists, have undergone a change upon this subject. The medication to which the tampons (cotton-wool) are subjected is with a mixture of glycerin and alum, and it is maintained that they act (1) as a support to the uterus; (2) as a depleting agent; (3) as an invigorating

agent to the uterus and vagina. The condition for which this treatment is especially applicable is retroflexion, and the symptoms which follow such a condition, especially from altered mechanical relations, are too well known to require specification. Prolapsus is also a condition which is amenable to this treatment. Improvement is the rule, by the adoption of this method, and sometimes cure may be effected. In other cases the subsequent use of a pessary completes a cure which has been already begun.—*N. Y. Medical Journal.*

Hysterectomy for Uterine Cancer.—In a recent discussion of the treatment of carcinoma uteri by extirpation of the uterus, before the Academy of Surgery, most of the surgeons agreed with the opinion expressed by Verneuil and Polaillon, that "hysterectomy would be a very good operation at the beginning of cancer, if it were less dangerous; but with the progress of surgery its dangers may be lessened. It is, therefore, an operation for the future; but under the present conditions, the mortality being one in three, the surgeon has not the right to resort to it, because fortunate results from it are far from being frequent."—*Bull. Gén. de Thérapeutique.—Medical Times.*

III.—DISEASES OF CHILDREN.

Management of Newborn Infants. — The *Medical World* says: In the management of the new-born infant we are gradually approaching Nature's methods. In the maternity department of the Philpdelphia Woman's Hospital the management of new-born babes has been as follows:

As soon as the head is born the eyes are washed with an antiseptic solution. When the body is born the child is left in the bed to await the expulsion of the placenta. No effort is made to remove the placenta under half or three-quarters of an hour; before this time it is generally expelled by nature. When the placenta is expelled it is placed in a pan, and the child is wrapped up and laid away with the placenta still attached.

The child is now left and the attention is given to the mother. After the mother is cared for the child receives attention. By this time the pulsations in the cord have long since ceased. The cord is now cut and the blood "stripped" out of the stump, but neither end is ligated. The stump is not dressed, nor is any band put around the child's body. The child is neither washed nor dressed, only a diaper and a simple "slip" or gown is put on, and then it is warmly wrapped up and put in a little bed to itself. After twenty-four hours it is taken to the babies' bath room (which is properly heated) and there it is washed and dressed.

Dr. Tyng, the physician in charge, tells us that since this plan has been adopted the babies get along much better. We were in the wards

of this department about an hour, and during this time there was not a single cry from the babies. They all seemed contented and happy, and were doing well. We are convinced that washing the child immediately after birth, or keeping it half naked for a long time during the process of careful dressing is not good practice.

Treatment of the Initial Phenomena of Scarlet Fever by the Sulphate of Quinia (*Jour. de Med. de Paris*).—In the development of scarlet fever it is noticeable that the fever follows a regular course, with exacerbations which occur periodically. Paying attention to these intermissions and administering sulphate of quinine from the beginning, it was noticed by the author that the intensity of the fever was lessened, and the recurrence retarded until the eruption had almost disappeared. Each recurrence attended or called forth renewed activity in the development of the the eruption, the last recurrence being the most marked one. It is without danger, however, if the quinine has been given in suitable doses. In severe cases of the disease it is believed that quinine lessens their gravity. The accidents which follow scarlatina are due to a retention of the poisonous principle in the blood, which acts similarly to the poisonous principle in malarial fever. The difference in them consists in the rapid progress of the scarlatinal elements. Quinine given as a preventive is a most excellent means for this purpose, or for combatting them when they have already appeared. The author believes he is the first who has published a recommendation for the use of quinine in this disease. In severe cases he recommends the daily use of a gramme of the sulphate of quinine for two or three days, or until the exacerbations have ceased. — *The Medical Press.*

Notes on Resuscitation of the Newly-Born and on the Treatment of Poisoning by Anesthetics.—Charles Egerton Jennings, L.R.C.P.Lond., contributes the following to the *British Medical Journal :*

Whilst resident accoucheur at the London Hospital, I was once performing artificial respiration, after Silvester's method, with insufficient assistance, in a cottage, on an infant, when it appeared that the chest could not expand, since the air, immediately on entering the larynx, forced the epiglottis, *ipso facto*, like a valve, over the superior orifice of the organ.

The nurse—an ancient one, and not one of an intelligent order—could not be trusted to hold the tip of the child's tongue, small and slippery, with firmness. Perceiving that a darning-needle lay threaded on a pincushion, I thrust the needle through the tongue, and directed forcible traction to be made on the loop of thread, whilst artificial respiration was recommenced. Never do I recollect a case of like character, where signs of animation appeared so quickly ; which, since they vanished on

relaxation of the tongue, and reappeared at once on the renewal of traction, were clearly due to that proceeding.

I venture to attach the greatest importance to forcible traction on the tongue, as a preliminary to artificial respiration in the newly-born, not merely having tested the efficacy of the plan on subsequent occasions, but having read in an article in Holmes' "System of Surgery" (third edition) that Sir Joseph Lister considers it invaluable where life is jeopardized by inhalation of chloroform.

But a careful consideration of the arguments which this great surgeon adduces to prove his view that "the beneficial effect of this procedure cannot be explained mechanically, but must be developed in a reflex manner through the medium of the nervous system" (*op. cit.*, vol. iii., p. 604) fails, to my mind, to convey conviction of the stability of the theory, since it seems more probable that, in chloroform-poisoning and in the asphyxia of new-born babies, the laryngeal apparatus is flaccid, owing to paralysis of its muscular apparatus, caused in the former instance by the specific action of the anesthetic, and, in the latter, due to previous disuse.

If this explanation be accepted, nothing is easier to understand than the frequent failures which follow artificial respiration, when the tongue has been previously withdrawn from the mouth, and the success which attends Silvester's method (the precaution having been adopted) as a means of resuscitating the newly-born, or of preventing death from anesthetic poisoning when solely threatened by laryngeal obstruction.

Should death appear imminent from causes other than laryngeal obstruction, only one method remains which can possibly avert dissolution —when the respiratory movements have ceased, when the circulation has stopped or is stopping, when galvanism has failed, and when the administration of diffusible stimuli, either in the form of inhalation or *per cutem*, would be useless—namely, the intravenous injection of fluid (medicated or otherwise), accompanied, under most circumstances, by simultaneous depletion. Five points would thus be gained : first, the re-establishment or the maintenance of the circulation ; secondly, the removal of part of the poison, and dilution of the remainder ; thirdly, where loss of blood had occurred, repletion of the vascular system ; fourthly, the opportunity for administering a physiological antidote, *e.g.*, in the case of chloroform, ammonia ; and, fifthly, the employment of the most powerful cardiac stimulant with which we are acquainted.

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Bibliography.

Diagnosis and Treatment of Diseases of the Heart. By CONSTANTIN PAUL, Member of the Academy of Medicine, etc., etc. Translated from the French. New York: William Wood & Co., 56 and 58 Lafayette Place. 1884.

This is a very thorough, complete and systematic treatise on diseases of the heart. The *First Part* of the book is devoted to general considerations on the Topography of the Heart. *Second*, Diseases of the Heart and its Membranes, and *Third*, of Treatment. The drugs which the author names especially as moderators of the hearts' action, are Digitalis, Bromide of Potash, and Convallaria Maijalis. His views upon the specific effects of digitalis scarcely agree with the present accepted views of therapeutists. Other excellent sections upon the hygiene of heart diseases, together with special forms of organic defect are noticeable. This volume is for March of Wood's Library of standard medical authors.

Practical Manual of Obstetrics. By DR. E. VERRIER, Lecturer on Obstetrics in the Faculty of Medicine of Paris. Fourth Edition. Enlarged and Revised. With the Four Obstetric Tables of Professor Pajot. First American Edition, with Revision and Annotations by Edward L. Partridge, M.D., Prof. of Obstetrics, etc. New York: William Wood & Co., 56 and 58 Lafayette Place, 1884.

This book announces itself under the modest title of *Manual*, and indeed is not so extended in matter as some of the Standard Works—nevertheless it is sufficiently full for the practitioner, and presents all that is useful. Besides, when a work on Obstetrics has reached its Fourth Edition from such an authority as Verrier, endorsed by Pajot, and now the Fifth Edition presented under the auspices of Prof. Partridge. There would hardly seem any propriety in making any extensive notice—more than to repeat its hearty endorsement. The busy practitioner will find the book a worthy addition to his library.

A Practical Treatise on Diseases in Children. By EUSTACE SMITH, M.D., Fellow of the Royal College of Physicians: Physician to the East London Children's Hospital, etc. New York: William Wood & Co., 56 and 58 Lafayette Place. 1884.

This work, announced as written at the special request of Wm. Wood & Co., is an entirely new candidate for professional favor; and one likely to step at once into note. The plan is given in *Twelve Parts*. 1. Acute Infectious Diseases; 2. Diseases Not Infectious; 3. Diathetic Diseases as Scrofula, Syphilis, etc.; 4. Diseases of ductless Glands; 5. The Nervous System; 6. Respiration; 7. Two Chapters on the Diseases of the

Heart; 8. Mouth and Throat; 9. Digestive Organs; 10. The Liver; 11. Génito-Urinary Organs; 12. The Skin. This scheme, as will be seen by this outline, afforded the author a very excellent skeleton on which to work out his book. The style is readable, and the views worthy of confidence. Price $5.

Hooper's Physicians Vade Mecum. A Manual of the Principles and Practice of Physic. With an Outline of General Pathology, Therapeutics and Hygiene. *Tenth Edition.* Revised by WM. AUGUSTUS GUY, M.B., Cantab., F.R.S., and JOHN HARLEY, M.D., Lond. F.L.S. Vol. I. Vol II. New York: Wm. Wood & Co.

But little seems proper to be said about a work that has been before the profession for more than fifty years, and has reached its tenth edition. As the American Publisher remarks—"revised and improved from time to time, it has always kept its place in the front rank as a reliable and concise treatise on the Practice of Medicine. Volume I is largely devoted to General Pathology and Therapeutics; the remainder of the First Volume and the Second are devoted to The Practice of Medicine. As this wonderful work has been regularly revised from Edition to Edition by able Editors, it has been kept fully abreast of the progress of Medical Science, and the physician will find it a most valuable source of study and reference. We think the Publishers have been especially happy in their selections thus far in the make up of The Library of Standard Medical Authors; and the remaining volumes for the current year promise to be equally valuable.

And now comes more *Poetry.* "*Medical Rhymes*" is the title of a new book published by J. H. CHAMBERS & Co. of St. Louis.

It is an unusually attractive book of the kind. It consists of a collection of poems, grave, sentimental and humorous, but devoted to medical men and things. These are selected from a variety of sources. Several of the choicest of Dr. Holmes poems have a place with selections from a great many others, indeed we were surprised that so many doctors had found time to cultivate the Verses. There are poems on *anatomical* love —on *Medicine—Surgery* and *Obstetrics*, and on a great many *miscellaneous* subjects. The whole is arranged by Dr. HUGO ERICHSON, Professor in the Quincy School of Medicine. The book is abundantly illustrated. S.

The Surgeon Generals Office has recently issued Vol. V. of the *Index Catalogue* of the Library of the Surgeon General's Office, U. S. Army. It runs from FLACCUS to HEARTH.

Of course we should as soon expect to give a detailed notice of the Unabridged Dictionary, as to review the contents of one of these ponderous volumes. As usual, however, we have a further exibit of the indefatigable and systematic work of Surg. J. S. Billings.

The season for Visiting Lists is now upon us. Already we have received The *Medical Record* Visiting List for 1885, with its well known excellent qualities. We have used this form for several years and have been well pleased. Price for 30 patients, $1,25, for 60 patients, $1,50.

And finally we have on our table a volume of Poems. The themes of the muse are not Medical, but the poet is a Physician. The volume is a neat and readable collection by Dr. N. M. Baskett, of Moberly, Mo., who seems very pleasantly to have amused himself in this way in the interval of waiting for patients. S.

The Question of Tying the Umbilical Cord after Labor.—Dr. John T. Booth, of Wyoming, O., relates the history of a case where an illegitimate child was born and the cord was cut but not tied. The probable object was to let the child bleed to death. Instead of this it did well, there being no hemorrhage at all. Dr. Booth raises the old query whether tying the cord is necessary. Some have claimed that it is not, and undoubtedly in many, if not in most cases, there will be no hemorrhage if the physician wait till the child has breathed a few times. But the present practice of tying is a safe and wise one.—*Medical Record.*

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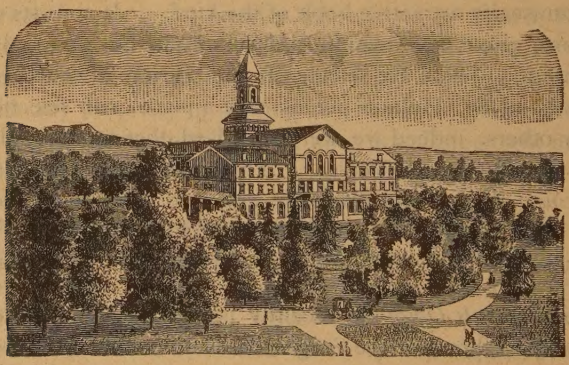

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